

104

# MATTERS RELATING TO THE FEDERAL BUREAU OF PRISONS

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4. J 89/1:104/21

Matters Relating to the Federal Bur...

## HEARING

BEFORE THE  
SUBCOMMITTEE ON CRIME  
OF THE  
COMMITTEE ON THE JUDICIARY  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

JUNE 8, 1995

**Serial No. 21**



Printed for the use of the Committee on the Judiciary

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# **MATTERS RELATING TO THE FEDERAL BUREAU OF PRISONS**

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**THURSDAY, JUNE 8, 1995**

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON CRIME,  
COMMITTEE ON THE JUDICIARY,  
*Washington, DC.*

The subcommittee met, pursuant to notice, at 9:39 a.m., in room 2237, Rayburn House Office Building, Hon. Bill McCollum (chairman of the subcommittee) presiding.

Present: Representatives Bill McCollum, Stephen E. Buyer, Howard Coble, Fred Heineman, Ed Bryant of Tennessee, Steve Chabot, Bob Barr, Charles E. Schumer, Robert C. Scott, and Sheila Jackson Lee.

Also present: Paul J. McNulty, chief counsel; Glenn R. Schmitt, counsel; Dan Bryant, assistant counsel; Aerin D. Dunkle, research assistant; Audray L. Clement, secretary; and Tom Diaz, minority counsel.

## **OPENING STATEMENT OF CHAIRMAN McCOLLUM**

Mr. MCCOLLUM. I'm going to call the subcommittee meeting to order, the Subcommittee on Crime, and welcome everybody to our hearing.

The hearing this morning is for the purpose of overseeing the work of the Federal Bureau of Prisons. A critical component of any government's effort to fight crime is the effective management of correctional facilities. Since it was created in 1930, the Federal Bureau of Prisons has been widely regarded as highly professional and nonpartisan by persons concerned with correctional issues, both inside and outside the Government. There's no question that the Bureau of Prisons' facilities are professionally and humanely operated.

No Bureau of Prison facilities has ever been subject to a court order with respect to living conditions. This is in no small part due to the excellence of its leadership and management personnel. Since 1930, only six persons have served as Director of the Bureau of Prisons. Few Federal agencies can make this boast.

I'm pleased to welcome the present Director of the Bureau of Prisons, Kathleen Hawk, and look forward to hearing and discussing the present conditions of the Bureau of Prisons with you, Kathy.

The challenges that she and her staff face and the ways in which Congress can assist the Bureau of Prisons in fulfilling its mission are why we're here today. While it may not be the subject of much

discussion today, I would like to publicly express my continuing support of the Bureau of Prisons' efforts to engage its inmates in meaningful labor. I've been especially satisfied with the work of the Federal Prison Industries program. Federal Prison Industries consistently produce quality goods for the Federal Government and provide beneficial labor for inmates, and in many cases teach them employable skills. I hope that in the near future we can begin a dialog about how to expand this worthwhile program beyond its present limitations, particularly as it relates to the marketing of Federal Prison Industries products.

Of course, no organization is perfect, and it is appropriate at this oversight hearing to review the recommendations made by the General Accounting Office over the last several years concerning how the Bureau of Prisons can operate more effectively and efficiently. I look forward to hearing from GAO's representative, which together with GAO's written statement will provide an overview of those recommendations.

It is also important today for us to take note of the fact that the Bureau of Prison population continues to increase at a rapid rate. By the turn of the century, the prison population will have increased by over 100,000 in less than 20 years. This trend is likely to increase in the future. The pressure that comes with this, along with the need to eliminate budget deficits, requires that this subcommittee consider proposals that would make the Bureau of Prisons operate more efficiently and enable it to provide more with less.

Today we'll hear from witnesses who will suggest ways to achieve those savings in areas of prison construction, the management and operation of prisons, and the provision of health care services to prison inmates. I look forward to hearing their ideas and trust that these proposals will further the public discussion of these issues.

Finally, we must face the reality that a high percentage of Federal prisoners require drug treatment while they're incarcerated. I recently met with a group of Federal judges who expressed frustration with the limited availability of drug treatment programs in Federal corrections. Last year's crime bill requires the Bureau of Prisons to treat 50 percent of all eligible inmates by the end of fiscal year 1995 and 100 percent of all eligible inmates by the end of fiscal year 1997. Given the cost of this treatment, it is proper for us to critically examine the effectiveness of drug treatment programs in prisons and the merits of the new benchmarks imposed on the Bureau of Prisons in last year's bill.

I look forward to hearing the testimony on this issue as well today, and I would at this point yield to my good friend and colleague and the ranking minority member, Mr. Schumer.

Mr. SCHUMER. Thank you, Mr. McCollum. I want to welcome Director Hawk and our other witnesses, and I'll keep my remarks brief. I just want to make a few points.

First, we have to be aware that every change we in Congress make in the Federal criminal laws impacts on the Bureau of Prisons. It's the end of a long chain of events we set in motion when we create new Federal crimes, establish longer prison terms, or push Federal law enforcement agencies to devote more resources to specific kinds of crimes. These things and others directly affect the

number of inmates in our Federal system, their ages, and other demographic characteristics, and how long they stay in the system.

Now, as everyone here knows, I am for mandatory minimums for a good number of crimes, and I am for long sentences for violent criminals. I'm also for beefing up the Federal role in going after violent criminals who use and traffic in firearms, explosives, and other types of activities. But we must—and let me underline “we must”—also be willing to provide the resources to the Federal Bureau of Prisons to do the job we set out for in the Criminal Code. If we just mandate longer sentences and we don't have more prison space, somebody is serving less time in jail, and that's a hoax on the people. For too long political leaders throughout the country, both parties, have done that, and I don't think that's fair and I don't think that's right.

Second, I welcome our exploring ways to privatize certain functions of the corrections system. It's clear to me that the market system and the competition that comes from free enterprise often encourages certain efficiencies. But we also have to be careful not to degrade key aspects of the system simply in pursuit of a mantra like “privatizing.”

Yesterday I happened to meet with a group of Federal employees from my State who were down here, and, you know, I just wish everyone would meet with them. You read the newspapers and it seems like, oh, 90 percent or 95 percent of Americans are hard-working people who go in to work and really care about their jobs, but the 5 percent who are Federal employees somehow are lagards. Meet the people; they also go into work when they have a 101 fever because they're dedicated to their job. They also care about their work. And this idea that, oh, one type of worker is a tough, hard worker and the other type is just a complete wastrel bugs me. The way to deal with that is just for all of us to sit down and talk to some of the Federal workers and see what they go through.

In any case, it's my view that we shouldn't be just degrading aspects of the system in pursuit of a mantra like privatizing. We have to be absolutely sure that nothing we do compromises the security of our correctional facilities. We can't put correction personnel at risk. I think none of us want to do that. And we must not endanger the communities in which correction facilities are located. We must also not diminish the role of the Federal corrections system as a model system because, let me tell you, compared to my State, the Federal system works and is run a lot better. It maybe has not as tough a job because the most violent criminals end up in the State system. But, nonetheless, if you compare the two—go to Riker's Island, go to the Metropolitan Correctional Facility—it's quite different.

We have to be sure that we treat employees of the Bureau of Prisons fairly. We can't dump men and women who have faithfully devoted careers to public service in often dangerous and also trying circumstances. We can't just dump on them. We have to consult in good faith with employee representatives along the way, every step along the way, to any kind of privatization.

Those are the two points I wish to make here, Mr. Chairman. I welcome these hearings. It's one of the jobs of the subcommittee that's important, and I thank you for calling the hearing.

Mr. MCCOLLUM. Well, you're quite welcome, Mr. Schumer. I thank you for your opening statement this morning.

I trust—Mr. Buyer, would you like an opening statement?

Mr. BUYER. Well, I'm not going to give a long opening statement. I just want to make a quick comment. I'm not sure exactly where Mr. Schumer was going with his insinuations with regard to attacks on the 5 percent, and I don't want to get into that kind of discussion.

I would just—maybe I'll have a conversation with him in the hall and try to figure out what exactly he meant by that. But I think there are a lot of us, whether they're conservative Democrats or Republicans, on the issue of trying to reduce the size of bureaucracies, that no way is there any form of blame games upon particular individuals, no matter what they do. We're going after bureaucracies and we do understand that when you go after bureaucracies that there are individuals and there are people and there are faces at the end of those bureaucratic pyramids. So while we do that, we are also sensitive to the people in there; likewise, I think the President of the United States also understands that as he's eliminating 250,000 Federal jobs. So I want to make sure that I understand the tone of the comment and that it's in that vein.

Thank you.

Mr. SCHUMER. This is not intended—if the gentleman will yield, since he mentioned my name——

Mr. BUYER. Yes.

Mr. SCHUMER [continuing]. As a partisan comment.

Mr. BUYER. Thank you.

Mr. MCCOLLUM. Mr. Coble.

Mr. COBLE. Mr. Chairman, I thank you for having conducted this hearing. I'll be very brief.

I just want to extend on the comments of the gentleman from Indiana. We have a saying, Mr. Chairman, a word that's frequently used in the rural South, from which I hail, and that word is "sorry." When people don't perform, he's of a sorry lot. Well, I know Federal employees who are sorry; I know some, conversely, who are exemplary. I know Congressmen who are sorry and I know some who are exemplary. And I don't think anybody should be above criticism; I don't care where they work.

So having said that, I look forward to the hearing as we go along.

Thank you, Mr. Chairman.

Mr. MCCOLLUM. Thank you for enlightening us, Mr. Coble, about "sorry" things. [Laughter.]

Dr. Hawk, I just welcome to have you here this morning. I want to introduce you formally at this point.

I'd like to welcome our first panelist, Kathleen Hawk, Director of the Federal Bureau of Prisons. Appointed in 1992, Dr. Hawk is only the sixth Director of the Bureau since its establishment in 1930, a comment I made in the opening statement, really not with naming you.

Dr. Hawk began her career with the Bureau in 1976 as a psychologist at the Federal Correctional Institution in Morgantown,

WV, where she later was named Chief of Psychology Services, after completing her doctorate in education from West Virginia University in 1978. In 1983, Dr. Hawk was selected as a senior instructor for the Bureau of Prisons Staff Training Academy. In 1985, Dr. Hawk became Associate Warden at the Federal Correctional Institution in Ft. Worth, TX. Dr. Hawk was named Warden of the Federal Correctional Institution in Butner, NC, in 1987. So she ought to be familiar with Mr. Coble's "sorry folks," as well as exemplary. [Laughter.]

In 1989, Dr. Hawk was selected as an Assistant Director of the Bureau of Prisons in charge of the program review in the Bureau of Prisons' central office. She became Bureau of Prisons Director in 1992. That same year she received the Attorney General's award for excellence in management.

So, all in all, we've been saying some nice things about the Bureau of Prisons this morning, but we want to hear the report. We know that it isn't all that rosy, but we overall are pleased with your management.

So please let us hear from you.

**STATEMENT OF KATHLEEN M. HAWK, DIRECTOR, BUREAU OF PRISONS, ACCOMPANIED BY THOMAS R. KANE, ASSISTANT DIRECTOR**

Ms. HAWK. Thank you, Mr. Chairman and members of the subcommittee. I certainly appreciate the opportunity to appear before you today and discuss some of the issues that are of importance to the Bureau of Prisons.

With me today is Tom Kane, one of the Assistant Directors of the Bureau of Prisons.

Growth is certainly one of the most critical issues for the Bureau. Since September 1984, our total inmate population has increased nearly 173 percent, from 36,000 inmates to almost 99,000. We expect our total inmate population to approach 130,000 by the end of the decade. This is the result of many things, including more resources being devoted to law enforcement, the elimination of parole at the Federal level, reductions in good time, and the effects of sentencing guidelines and mandatory minimum sentences.

Due to these changes in sentencing laws, our inmates are serving much longer sentences, which results in more older inmates. And these inmates present health care challenges and other unique problems. Additionally, the number of women inmates in our system has more than tripled over the last 11 years. Non-U.S. citizens now make up about 25 percent of our population, presenting us with language, cultural, and health care challenges. There's also been a dramatic increase in the number of young, aggressive Federal inmates who oftentimes have been involved with drug and firearm offenses in the community. Many of these inmates are prone to engage in gang and violent activities, and to confront prison staff and defy institution regulations. Over 61 percent of our inmates are drug offenders and about 31 percent have moderate to severe drug abuse problems.

These changes in our population, that I noted, have obvious resource implications. The Bureau's \$2.9 billion budget request for fiscal year 1996 will allow us to continue our expansion program,

as we add approximately 9,000 new beds at 12 locations in the upcoming year. We're managing our construction program and operations cost-effectively, in order to assure wise expenditure of taxpayers' dollars. Through extensive double-bunking, we're operating at a current crowding level of 125 percent of our capacity. We also intend to reduce administrative staff in general, particularly targeting personnel and financial support areas, in order to assign more personnel to our field locations.

In addition, the President's fiscal year 1996 budget contains an increased reliance on private sources to operate future Federal pre-trial detention facilities and the majority of our future minimum and low-security institutions. This will reduce the number of additional full-time equivalency positions associated with our unavoidable growth.

Concerning our facility operations, effectively managing crowded Federal prisons requires continued support for programs to productively occupy increasing numbers of inmates, and work is certainly one of our most important programs. Work reduces idleness. It also instills job skills and good work habits. It enables inmates to pay for child support and fines and make restitution to victims. All inmate jobs at our institutions—whether it be food service, facility maintenance, or whatever—are important, and every medically-able Federal inmate has an assigned job. However, our Federal Prison Industries program, which you referenced, Mr. Chairman, is especially important to us, as it employs about 25 percent of our inmates. We believe it's essential that this vital industrial work program be allowed to expand prudently and at a rate that will keep pace with our population growth, while not unduly impacting the private sector.

Essential programs, such as drug treatment, literacy, and vocational training, are necessary to maintain our institutions in a safe, secure, and cost-effective manner, as well as to prepare our inmates when they are released from our institutions. This is particularly true at a time when we're dealing with a much more difficult inmate population. We're particularly proud of our multitiered drug abuse treatment program, and I would be very happy to discuss it in more detail with you.

Likewise, the Bureau's mandatory education program addresses the literacy needs of all of the approximately 40 percent of inmates who come to us without a high school education. Our research shows that these programs are not only key management tools, but also have a significant impact upon recidivism once inmates are released.

I would be remiss if I did not mention my concern that proposed changes in the Federal retirement program now incorporated into both House and Senate budget legislation may have the unintended, but serious effect of motivating many of our senior staff in the Bureau of Prisons to retire at a time when we more than ever in our history need their level of experience and their knowledge.

Finally, I'd like to mention inmate health care, which presents us with the challenge of holding the line on costs while meeting the legitimate needs of inmates who present far greater medical health care requirements than does the average citizen. We are using a



number of strategies that enable us to provide inmate health care cost-efficiently.

Let me close by acknowledging the work of the more than 27,000 Bureau staff throughout the Nation who continue to perform their difficult and oftentimes dangerous work in an outstanding manner. The very dangerous aspect of prison work became very, very real to us in the Bureau of Prisons this past December with the tragic death of our correctional officer, D'Antonio Washington, who was brutally beaten to death by an inmate at the U.S. Penitentiary in Atlanta, GA. Despite this tragedy, the Bureau has continued to operate effectively, a fact that's a tribute to the hard work and dedication of Bureau employees, who are dealing with crowded institutions and more challenging offenders, while still maintaining public safety.

This concludes my formal statement, Mr. Chairman, and I'd be pleased to answer any questions from you or other members of the subcommittee.

[The prepared statement of Ms. Hawk follows:]

PREPARED STATEMENT OF KATHLEEN M. HAWK, DIRECTOR, FEDERAL BUREAU OF PRISONS

Mr. Chairman and members of the Subcommittee, I appreciate the opportunity to appear before you today to discuss a number of issues of importance to the Bureau of Prisons. My statement will focus on the following issues: the Bureau's population growth; the resources the Bureau needs to sustain that growth; Federal Prison Industries operations; the value of correctional programs and activities; death penalty issues; privatization; inmate healthcare issues; and, the work of the National Institute of Corrections.

GROWTH AND THE CHANGING POPULATION

The Bureau of Prisons is responsible for almost 99,000 Federal inmates. About 88,000—or almost 90 percent—are confined in 81 Bureau-operated facilities, and another 9,8000 inmates are confined in contract halfway houses, privately-operated facilities, and State or local facilities. To manage the system, the Bureau employs over 27,000 total staff.

About 61 percent of Federal inmates are confined for drug offenses, primarily drug trafficking and importation; another 10 percent are sentenced for robbery offenses; and about 9 percent are serving time for firearms and explosives-related offenses. Approximately 56 percent of Federal prisoners have an official record of involvement in violence (to include current offense, prior offenses, or the possession or use of a weapon during the commission of an offense).

The average sentence length of Federal inmates is 9½ years. The average age of the population is 37 years. Seven percent of Federal inmates are women, and 25 percent are non-U.S. citizens. Regarding race, 37 percent are black and 60 percent are white. Regarding ethnicity, 26 percent are Hispanic.

In addition, an analysis completed in November 1993 by the Department of Justice found that a substantial number of drug law violators can be classified as "low level." Using the criteria of no record of current or prior violence, no involvement in sophisticated criminal activity, and no prior commitment, around 21 percent of the sentenced Federal inmate population is in this category. Further, if non-U.S. citizens are removed, for whom adequate prior criminal records are often not available, we find that about 16 percent of sentenced U.S. citizens qualify as "low level" drug offenders.

These data indicate a wide range in the characteristics of Federal inmates. To meet the range of custodial needs they present, the Bureau divides its facilities into four security levels—minimum, low, medium, and high. Inmates are classified using a risk assessment system that determines custody assignments for inmates which parallel these facility security levels. This system enables the Bureau to assign inmates to institutions which meet their security requirements. The Bureau also operates detention centers to house pretrial detainees and medical referral centers for inmate-patients. Federal detention centers and medical referral centers house inmates of all custody categories.

Several Bureau of Prisons research studies conducted between 1978 to 1993 have indicated that the recidivism rate in the Federal prison system has remained at approximately 40 percent. To arrive at these recidivism figures, we consider incidents of rearrest or revocation of supervision, not just re-imprisonment, within 3 years after release.

#### *Numerical growth*

From 1960 to 1980, the size of the Federal inmate populations was relatively stable, varying between 20,000 and 30,000 inmates. However, beginning in 1980, the population began to increase significantly. Growth between 1980 and 1986 primarily reflected an increase in investigatory, prosecution, and judicial activity.

However, beginning in 1984, new legislation has dramatically altered sentencing in the Federal criminal justice system. Most of the Bureau's recent growth is a result of mandatory minimum sentences enacted in 1986, 1988, and 1990, as well as the Sentencing Reform Act of 1984, which established determinate sentencing, abolished parole, and significantly reduced good time. The management and budget implications of this increase are central issues to us in the Bureau of Prisons today.

Since September 1984, the Bureau's total inmate population has increased from 35,800 to almost 99,000 today. Based on current projections, the inmate population is expected to approach 130,000 by the year 2000. These population projections do not account for possible increases which could result from the Violent Crime Control and Law Enforcement Act of 1994 or from further legislation now under consideration by the Congress.

#### *Drug offenders*

Perhaps the most dramatic change in our inmate population has been the growing number of drug offenders. In 1984, about 30 percent of our sentenced population was convicted of a drug offense. Currently, over 61 percent of Bureau inmates are serving sentences for drug offenses, and we expect that by the year 2000, that proportion will be around 70 percent. Also, the average prison length of stay for drug offenders has increased significantly from 23.1 months in 1985 to 68.7 months in 1993.

The primary reason for our burgeoning population is the combination of increased admissions for drug offenders and an almost threefold increase in their length of stay.

#### *The "90's inmate"*

Included in this increased number of drug offenders is a sizable group of inmates who are particularly likely to have been involved with violence and firearms while in the community. While in prison, we have found that they are inclined to engage in gang activities and other group misconduct.

This subgroup consists of young, aggressive, generally urban individuals who, before coming to prison, were involved in street-gangs that emphasized use and sale of drugs, high levels of violence, and gang solidarity. Examples include the Crips and Bloods from Los Angeles, the Mexican Mafia from Southern California, the Videlords from Chicago, and the Latin King, from Northeastern cities. The number of gang members and affiliates of gangs in our population has increased dramatically in recent years.

The "90's inmate" represents a relatively new phenomenon for the Federal criminal justice system. They present the Bureau of Prisons with a new challenge—dealing with individuals who have not been shaped as we would hope by society's major socializing influences. These inmates have little regard for authority and are quick to confront staff. They have few internal controls and engage in group actions more quickly to solve what they see as problems or grievances. They have little or no desire to abide by the rules of the prison. Their street gang background and disruptive values give them a common, negative frame of reference and provide peer support that becomes stronger as more and more of them come into our prisons. Many of these offenders are serving very long sentences and believe that they have little or nothing to lose from their disruptive behavior.

Inmates displaying these traits have had a profound impact on the Bureau, contributing to an increase in the number of group disturbances in recent years. For example, between 1989 and 1994, the number of group misconduct incidents increased 383 percent. In addition, a recent Bureau study indicated that assaults on either staff or inmates increased 12.3 percent over the 2½ year period from January 1992 to June 1994.

In response to this more aggressive and volatile population, we are modifying existing facilities and building new institutions using more secure design features, providing enhanced staff training on how to manage a more diverse population, and

ensuring that inmates are incarcerated in sufficiently secure facilities resulting from revised classification procedures.

We also are being challenged to find programmatic ways to manage these inmates so that they adopt appropriate coping strategies and behavior. Many have to learn to deal with the prospect of very long, even life, terms in prison. Others must be socialized at a very basic level in order to help them control aggressive and violent reactions. And still others must be helped in developing basic work habits as well as specific literacy and other skills.

### *Citizenship*

The Bureau has gone from fewer than 1,000 non-U.S. citizens in its custody in fiscal year 1980 to 23,438 as of March 1995. Almost 25 percent of the total Federal inmate population is now in this category. Many of these inmates come from countries directly involved in drug manufacture, importation, and distribution. Of the non-citizens in our custody, more than 60 percent are from Colombia, Mexico, and Cuba. Such a large non-U.S. citizen population has many implications for the Bureau, especially relating to language differences, cultural sensitivities, and health care needs.

### *Women inmates*

The number of women inmates in the Bureau of Prisons has more than tripled over the past 11 years. Until recently, this group was growing at a significantly faster rate than the number of male inmates. In September 1984, the Bureau had nearly 2,000 women offenders, making up 5.7 percent of the total inmate population. Today, there are 6,497 women inmates in Bureau facilities, making up over 7 percent of the Federal inmate population. This increase in the number of women inmates has implications for us in terms of facilities, healthcare needs, and programmatic needs—particularly those involving family issues.

### *Age characteristics*

The Federal inmate population contains significantly more older offenders than in the past—and will continue to do so—as we experience the effects of longer, non-parolable sentences being imposed. This brings us face-to-face with a number of problems associated with aging inmates, particularly increased healthcare needs.

However, with the aforementioned changes in law and sentencing practices, we are also experiencing an increase in the numbers of younger offenders. Therefore, the average age of Federal inmates has remained stable in recent years because the increase in the younger age group counterbalances the coincident increase in the older population.

### *Staff*

The Bureau employs approximately 27,000 staff, just under 84 percent of whom work in Federal prisons on a daily basis. Around 44 percent of institution employees are correctional officers and correctional supervisors. The other 56 percent include the institution executive staff, as well as service and program staff involved in functions such as food service, medical care, education, prison industries, psychology services, and facility maintenance.

All Bureau of Prisons' employees, no matter what their job specialty, are "correctional workers" first. This basic tenet of the Bureau means that any employee, from warden to secretary, may be called upon to perform security-related duties when needed, and all are trained for such response. When institution needs dictate, all staff are called upon to perform searches, to assist in escape hunts, to quell disturbances, and generally to maintain the security of the institution. An October 1991 GAO study determined that this practice enables the Bureau to operate with about a 27 percent higher inmate-to-staff ratio than State prisons.

The Bureau could not have coped with the inmate growth or with the dramatic changes in the inmate population without the outstanding efforts of its staff. There are numerous demands placed on Bureau employees every day as they deal with crowded institutions, new types of offenders, and the ever-present need to contain expenditures while still maintaining public safety.

Regrettably, the true cost of maintaining public safety and order in Federal prisons became very real for us this past December with the death of Correctional Officer D'Antonio Washington who was brutally beaten to death by an inmate at the U.S. Penitentiary in Atlanta, Georgia. Though this isolated incident is terribly tragic, it is fortunately not typical. Despite our growth and changing population, the Bureau has continued to operate effectively—a fact that is a tribute to the hard work and dedication of our employees.

## RESOURCES NEEDED TO SUSTAIN GROWTH

In light of the Bureau's dramatic population increase and the expectation that it will continue through the end of the decade, I would like to turn my attention to the implications of this growth on the Bureau's resource needs.

*Budget*

The Bureau's total budget is about \$2.64 billion for fiscal year 1995. In the face of the expected population growth, and to keep the Bureau's overcrowding level manageable through the activation of new Federal prisons, the President has requested a budget of \$2.98 billion for fiscal year 1996.

This budget request, and the programs and activities it will support, reflect our ongoing efforts toward efficiency and cost-effectiveness, while continuing to provide effective public protection, a safe working environment for our staff, and a secure but humane environment for our inmate population. In the current atmosphere of cost containment, our entire management team is dedicated to making the most prudent use of resources.

*Workforce issues*

The Bureau is expected to manage this period of unprecedented growth within full-time equivalency workyear limitations that are necessary in the context of restraining overall government growth. Clearly, additional staff will be needed for the Bureau to activate the new institutions it will be operating, but we are not relying solely on newly-authorized positions to meet these needs. As much as possible, we are moving positions to institutional posts to increase our ability to manage the population growth. We will further reduce our administrative support staff—which we believe is already lean—by an additional 25 percent over the next 4 years. This will be accomplished by consolidating and reducing staff in the areas of personnel, procurement, budgeting, and accounting.

This is a particularly critical period for us in terms of workforce issues. Today, over 700 Bureau staff in GS-12 and higher positions are eligible to retire—36 of these employees are part of the Bureau's 118 top management staff (wardens and Executive Staff members). Between now and 1999, almost 1,400 Bureau staff in GS-12 and higher positions will be eligible to retire. The potential loss of so many seasoned employees at a time when our rapid expansion program requires greater reliance on our experienced staff to offset the inexperience of so many new employees is cause for concern.

This situation could be severely aggravated by proposed changes in the Federal employee retirement system. The proposals now being considered generally are perceived by staff as being adverse to their interests. Employees who are now, or will soon be, eligible to retire are watching this situation closely. If proposed retirement system changes are enacted, we could experience an accelerated drain of these critical personnel resources at just the time when we need them the most.

*Strategies for managing crowding*

Our system-wide overcrowding rate is 125 percent. The Bureau's capacity rating system assumes 100 percent double-bunking at minimum- and low-security prisons, 50 percent double-bunking of rooms or cells at medium-security prisons, and 25 percent double-bunking at high-security prisons. This is the method used to calculate our current 125 percent crowding rate. For comparison purposes, however, using a one-inmate, one-cell standard—which is the typical standard of most States—the Bureau is operating at 174 percent of capacity.

The fact that the Bureau has been able to successfully manage growth and crowding of this magnitude also is a testimony to the Congress' willingness to appropriate substantial resources in support of Executive Branch initiatives, in order to add capacity to the Federal Bureau of Prisons. Given changes in our rated capacity plan, as well as funding approved since 1989 for new construction, for conversion of surplus facilities, and for expansion of existing facilities, the Bureau has added about 36,000 beds between fiscal years 1989 and 1994. Between now and 1999, we anticipate bringing on-line an additional 36,000 beds for which funding has already been provided by the Congress or which is included in the fiscal year 1996 request.

In fiscal year 1996, we plan to activate 9,197 new beds with the opening of 7 new prisons and expansions at 5 existing facilities. The new prisons are a low-security facility and a minimum-security facility in Beaumont, Texas; a low-security facility and a minimum-security facility in Taft, California; a low-security facility in Forrest City, Arkansas; a low-security facility in Yazoo City, Mississippi; and a detention center in Brooklyn, New York. Expansion projects will add capacity at our facilities in Tallahassee, Florida; Lompoc, California; Fort Worth, Texas; Lexington, Kentucky; and Milan, Michigan.

We are very sensitive to the budget constraints the Administration and Congress face. We have approached our construction program with the view that every effort must be made to manage the program cost-effectively and ensure wise expenditure of taxpayers' money. One clear dilemma, however, is the fact that budget realities appear to be in conflict with the continuing growth of the Federal Prison System. Even if the rate of growth is slowed, the population will continue to increase in absolute numbers, due to such factors as increased length of sentences. As a result, our bedspace capacity expansion program must continue in order to prevent future increases in overcrowding.

#### WORK PROGRAMS AND FEDERAL PRISON INDUSTRIES

##### *Inmate work assignments*

The Bureau's primary correctional program is work. All able-bodied inmates in our institutions are required to work. Institutional services jobs for inmates include food service workers, orderlies, plumbers, painters, and groundskeepers. Some minimum-security inmates work off institutional grounds for other Federal entities such as the National Park Service, the U.S. Forest Service, the U.S. armed services, and the Department of Veteran's Affairs. We know from experience that keeping inmates busy and productive is critical to managing a safe and secure prison. Meaningful work reduces idleness and the stresses associated with crowding. Appropriately-structured prison work teaches marketable vocational skills and instills work habits in offenders.

Inmates earn modest wages in their institutional services jobs—from \$.12 to \$.40 per hour. A portion of these wages can help meet the financial obligations of inmates' families. In addition, the Bureau's Inmate Financial Responsibility Program collects money from inmates to pay court-ordered fines, restitution, and other monetary judgments.

##### *Federal Prison Industries*

Federal Prison Industries (FPI) is a wholly-owned Government corporation whose mission is to employ Federal prisoners, by manufacturing products and providing services for other Federal agencies. FPI employs about 25 percent of Bureau inmates in 100 factories at 51 Federal prisons. These inmates produce a wide variety of goods such as furniture, textiles, electronics, and graphics and are engaged in a variety of services such as printing and data processing for the Federal market. Inmates working for FPI earn between \$.23 and \$1.15 per hour.

Federal Prison Industries is first and foremost a correctional program. In fact, the Bureau of Prisons considers it to be one of the agency's most important programs. Not only is it the primary vehicle for meeting the Bureau's statutory mandate to employ and train inmates, but by reducing inmate idleness and boredom, it is essential to the security of Federal correctional institutions and the communities in which they are located, and to the safety of inmates and the correctional staff who work at those facilities.

It should also be stressed that FPI is a Federal program that really works as it was intended. In a study of over 7,000 Federal inmates over a 5-year period, it was shown conclusively that inmates who had worked for FPI were better adjusted while incarcerated, were more likely to find and keep a job upon release, were more likely to earn higher wages, and were significantly less likely to return to a life of crime than similar inmates who had not worked for FPI. It should also be emphasized that FPI does not receive congressional appropriations for its operations, which is particularly important in these times of fiscal and budgetary constraints.

Our experience indicates that an FPI employment ratio of approximately 25 percent of the eligible population is necessary in order to manage our institutions. Thus, FPI will need to create an additional 4,000 to 5,000 inmate jobs by the year 2000 as the Bureau's population grows, to maintain an acceptable employment level. Insofar as possible, employment needs will be met by balancing expansion in our current lines of products and services with diversification into new areas.

In the production of its goods and services, FPI is committed to working cooperatively with the private sector, particularly small business, to develop partnerships that can be mutually beneficial and meet the inmate employment demands. While some of the products manufactured by FPI are produced by small businesses as well, FPI also assists small business through procurement of raw materials, component parts, supplies, equipment, and services. In fact, FPI has an outstanding record of purchasing from small and small-disadvantaged businesses, most of which are businesses in the communities where FPI factories are located. The local economy also benefits from FPI's presence through the salary money spent by FPI civil-

ian staff. FPI is considered a "good neighbor" to these businesses and to the entire community as well.

#### CORRECTIONAL PROGRAMS

Meeting the challenges posed by a growing and changing prison population involves more than just providing bedspace and work opportunities. Prison management involves providing programs that are designed to manage the Federal inmate population in a cost-effective manner, and that will improve the chances an inmate has for successfully returning to the community and remaining crime-free.

The confinement of inmates gives us the opportunity to offer programs that potentially provide a benefit to society through future crime reduction. To that end, the Bureau offers an array of correctional programs such as drug treatment, literacy, vocational training, parenting, and others, which include activities designed to teach inmates to use free time (when not at work or in educational programs) in a positive way.

##### *Drug treatment programs*

A significant percentage of the Federal inmate population—about 30 percent—have a history of moderate to severe substance abuse and would gain the greatest benefit from residential substance abuse treatment. Other offenders with lesser substance abuse histories require somewhat less rigorous drug treatment or drug education programs. We believe that providing quality treatment can help these inmates avoid relapse after release. In many cases, being able to remain drug-free is a major determining factor in that individual remaining crime-free as well.

The Bureau offers a multi-tiered approach to substance abuse treatment consisting of drug education, counseling services, residential treatment, and transitional services. Upon admission, we determine whether an inmate has a history of drug use, a drug-related offense, or a judicial recommendation to participate in a drug treatment program. If an inmate's record reveals any of these elements, the inmate is required to participate in a 40-hour Drug Abuse Education course, available in every Bureau institution. In addition, as part of the standard admission screening, we interview inmates about their past drug use in order to determine their need for drug treatment. The information-oriented drug education program is designed to motivate inmates to participate in further treatment programs. There are two basic types of substance abuse treatment available beyond the drug education program: "residential" treatment and "non-residential" treatment.

As noted above, inmates with histories of moderate to severe levels of drug abuse are eligible for residential treatment. Those who participate in residential drug treatment are housed in separate living units designated strictly for those undergoing drug treatment. Currently, the Bureau of Prisons operates 34 residential treatment programs, with a total of nearly 3,200 beds available. These residential programs are 6 to 12 months long, provide a minimum of 500 hours of drug abuse treatment, and involve extensive individual and group counseling. The strategies used in residential drug abuse treatment place responsibility for change on the individual by demanding compliance with the rules and regulations of treatment, encouraging the inmate to accept "ownership" of the norms of treatment, and motivating the inmate to make a firm commitment to positive change. Residential treatment programs are generally considered most effective when delivered toward the end of an inmate's sentence.

"Non-residential" drug treatment is available for inmates who have less severe drug histories, have serious mental health problems, do not have enough time left on their sentences to participate in one of the residential programs, or are unable or unwilling to participate in a residential program. These inmates are not housed in a separate drug-treatment living unit; instead, they are part of a prison's general inmate population, or live in some other specialized unit (such as a mental health unit). The non-residential drug treatment services available to these inmates includes individual counseling, group therapy, and specialty seminars (such as Cocaine Anonymous). In addition, non-residential programs include aftercare treatment for inmates who have successfully completed the residential drug treatment program and have returned to the general inmate population.

The first few months following release from prison are critical with regard to adjustment back into society. To facilitate this adjustment, when an inmate is transferred from an institution to a halfway house, or is released from custody to the supervision of the U.S. Probation Office, the final treatment and relapse-prevention plan is forwarded to the community supervising authority to ensure treatment continuity. Once in the community, graduates of the residential program are required to participate in transitional treatment. Transitional treatment is provided through

community-based treatment providers whose treatment regimen is similar to the Bureau's, ensuring consistency in treatment and supervision.

#### *Literacy and vocational training*

Literacy is a major problem for many of our inmates. Approximately forty percent of prisoners in the Federal prison system do not have a high-school level education. As a result, the Bureau requires inmates to participate in literacy programs, with the goal of every inmate ultimately being able to function at the 12th-grade or GED level. A recent Bureau study has confirmed that there is a reduction in recidivism for inmates who have completed the education program. Inmates who spent at least a year in prison and successfully completed one or more education courses in a year, demonstrated a 15.7 percent reduction in the recidivism rate over a 3-year period.

Inmates are required to participate in basic education classes for 120 days, after which they may opt out. However, unless they achieve the high school equivalency standard (or fall within certain other narrow exceptions), they will not be promoted above entry-level positions in Federal Prison Industries or institution jobs, and their good conduct time will not be vested. In fiscal year 1994, 5,940 of the 7,000 inmates tested received their GED.

A wide variety of vocational programs are available to Federal inmates. These are training programs in approximately 40 different occupational areas and include apprenticeship programs (which are certified by the U.S. Department of Labor's Bureau of Apprenticeship Training), continuing education programs, and post-secondary courses with a vocational emphasis offered by local technical schools, community colleges, and other organizations. These programs meet the very real needs that many of our inmates have for job skills. In fact, as stated earlier in the discussion about Federal Prison Industries, a multi-year study completed in 1991 found that inmates who participated in Federal Prison Industries work or vocational training programs were significantly more likely than other inmates to obtain jobs and remain crime-free after release.

#### *Parenting*

The growth we have experienced, especially in the number of female inmates, has led us to enhance and expand the type of programs we offer in the area of parenting. Clearly, a well-designed parenting program for mothers and fathers can yield numerous rehabilitative and developmental benefits for parents and their children. We believe that the children of inmates may well become our inmates of tomorrow if adequate intervention does not occur.

The Bureau has offered Congressionally-mandated parenting programs at many of its facilities over the years. Parenting programs now exist in most Bureau of Prisons facilities. These programs strive to cultivate positive relationships between inmates, their spouses, and their children. Each program offers access to social services, volunteer, and community services, and opportunities to participate in family parenting education programs.

#### *Volunteers*

It is important to note that we rely heavily on the services of volunteers to make many of our programs more efficient. We consider volunteers to be a valuable resource, and nearly 6,000 private citizens have provided long and faithful service to our institutions and community corrections facilities. Volunteers serve many functions within the Bureau, but none is more important than the vital link they provide to the local community for both staff and inmates. Volunteers can help to maintain a more normal social environment within a prison by providing religious, social, educational, recreational, and other services that are an essential link between the prison and the community.

### INMATE MANAGEMENT TOOLS AND ACTIVITIES

We agree with those in Congress and the general public who believe that prisons should not be comfortable settings and should not afford inmates unnecessary privileges. Rather, prisons should be safe, secure, and humane, and should provide appropriate opportunities for inmates self-improvement.

These appropriate inmate activities and management tools—such as the minimal amount of good time still available to Federal inmates, recreational activities, and varied and nutritious meals—serve identifiable correctional purposes and should not be labeled as perks or frills. These elements are important as incentives for inmates and encourage the development of personal responsibility.

A combination of several factors has led to a Federal inmate population that is increasingly difficult to manage, including an increased number of inmates whose gang membership or affiliation reflects a readiness to use violence, an increased

number of inmates who possessed or used a weapon during the commission of their offense, coupled with longer sentences, restrictions on good time, and the loss of parole. A variety of correctional activities serves as a positive management tool in the absence of other incentives for inmates who are now serving more lengthy sentences in crowded Federal prisons.

As a practical matter, the only sanctions that are available to our staff for violation of institutional rules include forfeiture of good time and restriction from activities. For that reason, it is important to have a few appropriate privileges that can be withdrawn to help inmates understand that there will be consequences for irresponsible behavior. We are concerned that some have come to misconstrue these few reasonable activities as perks or frills, when in fact they have important value as correctional management tools.

#### DEATH PENALTY ISSUES

There are six Federal inmates currently awaiting execution under the 1988 Anti-Drug Abuse Act (21 U.S.C. § 848(e)) for murders committed as part of drug-related continuing criminal enterprises. With the passage of the Violent Crime Control and Law Enforcement Act [VCCLEA] of 1994, we anticipate many more prisoners convicted of capital offenses will be committed to Bureau of Prisons' custody.

Federal regulations (28 CFR Part 26), which became effective in January 1993, stipulate that Federal executions will occur in a Bureau of Prisons facility, under the auspices of the facility's warden and the U.S. Marshals Service. The method of execution will be lethal injection. In accordance with these regulations, we identified the U.S. Penitentiary at Terre Haute for this purpose and recently finished construction of a small death row unit and execution facility there.

However, use of the Terre Haute facility for Federal executions is in question because of a little-noted provision in the VCCLEA of 1994. Under the technical language found in the death penalty implementation section, which is now codified as 18 U.S.C. § 3596, executions for offenses are to be carried out under the supervision of the U.S. Marshals Service in the manner prescribed by the law of the State in which the sentence is imposed. In the case of a State without a death penalty, the court will designate a State with capital punishment and the execution will be carried out in that State, in the manner prescribed by the law of that State. For the Bureau, this means that the only VCCLEA-affected executions that could occur at Terre Haute are those for which lethal injection was permissible in the State in which the inmate was convicted.

We believe that it is highly desirable to have a uniform system for implementing Federal death penalties in a Federal institution. From a policy as well as a practical perspective, it makes no sense to burden States with this clearly Federal responsibility, particularly when the Bureau has a facility already built specifically for this task. To remedy this situation, we suggest that the language in 18 U.S.C. § 3596 be amended to provide for the uniform implementation of Federal death sentences in Federal facilities.

#### PRIVATIZATION

An increase in the Bureau's use of privatized corrections resources is a feature in the President's fiscal year 1996 budget. Under the proposed budget, the Bureau will contract with private firms to operate all future Federal pretrial detention facilities and many future minimum- and low-security correctional facilities.

This decision helps us to alleviate the tension between inevitable growth in the Federal inmate population and prison system while responding to Administration and Congressional initiatives to streamline Government operations. Privatization will help us live within available resources and do so without negatively impacting existing Bureau facilities or stretching our experienced staff too thin. Private corrections has achieved a level of maturity that permits us to house certain types of inmates in contract facilities. This approach reduces the number of full-time equivalency positions needed by the Bureau to activate institutions which are currently under construction.

#### HEALTH CARE PROGRAMS

The Bureau's health care mission is to provide essential medical, dental, and mental health services to inmates by professional staff consistent with acceptable community standards. To accomplish this mission in a cost-effective manner, we benefit greatly from the services provided by personnel of the U.S. Public Health Service (PHS). PHS personnel augment Civil Service employees to help fill medical, dental, and mental health, environmental health, and safety positions throughout the Bureau.



To meet the changing healthcare needs of our population, and to respond to the fiscal pressures we are experiencing, the Bureau has developed and implemented several major health services initiatives. These include a stratified system of medical care, a managed care emphasis, quality management strategies, a health promotion and disease prevention program, and an infectious disease control program.

#### *Health care costs*

In 1994, the Bureau spent \$267,106,000 for health care services. This translates to approximately \$3,202 per inmate, which is very close to the estimated \$3,229 the average U.S. citizen expended in 1993 for health care, according to the National Healthcare Expenditure Report.

Our costs in this area are quite reasonable, considering that our health care programs operate within the restrictive environment of prisons and that inmates typically have greater health care needs than the average citizen. Many offenders have long-standing medical and dental concerns which either have been neglected in the past, or which have resulted from dysfunctional lifestyles involving drug or alcohol abuse. The widespread prevalence of this situation leads us to believe our inmate population may be as much as 10 years older physiologically than its chronological age—a fact that has clear implications for health care programming and costs.

#### *Services and quality assurance*

To meet these needs, every Bureau facility operates, at a minimum, a primary care ambulatory clinic staffed by licensed and credential health care providers. This primary level of health care is augmented through the use, on a contractual basis, of community hospitals, consultants, and specialists. Some of our larger facilities have infirmity-type services for secondary treatment and recovery needs. We use these services when extensive hospitalization is not warranted. If an inmate's treatment needs are more extensive, a transfer is initiated to a Bureau medical referral center. We operate 6 specialized medical referral centers, each designed to meet specific tertiary care or chronic care needs. Some other Bureau facilities offer other specific sets of health care services to further enhance our stratified system.

In addition to the stratification of facilities and services, we further ensure cost-effective inmate health care under a managed care system that emphasizes quality assurance mechanisms, recruitment and retention of qualified clinicians, and cost containment strategies.

The Bureau is committed to the validation of our health care operations at the same level as community health care organizations. In addition to internal quality assurance programs, we actively participate in the accreditation programs of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)—the premier medical care accreditation organization in the United States. Most other correctional agencies pursue accreditation by the National Commission on Correctional Health Care—an accrediting body with standards tied more specifically to corrections. Our initiative in seeking JCAHO accreditation further ensures that we are providing health care consistent with community standards.

Only our newest medical referral center is not yet accredited by the JCAHO. As part of a full Bureau of Prisons health services accreditation strategy, 19 ambulatory care health services units at regular Bureau institutions were accredited by the JCAHO in 1994. Two health services units have been accredited so far in 1995, and 19 more are scheduled for accreditation during the rest of this fiscal year. Twenty-five health services units are scheduled for accreditation in 1996, and the remaining 11 ambulatory care health services units will seek accreditation in fiscal year 1997.

Our emphasis on managed care and quality improvement (including JCAHO accreditation)—coupled with a comprehensive health promotion and disease prevention program and an expanding focus on the prevention of communicable diseases—has resulted in our ability to control prison-specific interventional care, avoid expensive litigation, and contain overall costs to the greatest extent possible.

#### NATIONAL INSTITUTE OF CORRECTIONS

In today's climate of reinventing government and ensuring lean but responsive and effective government services, the National Institute of Corrections (NIC) stands out as having a proven track record for providing fast, low-cost, customer-oriented service. In fact, NIC serves a unique Federal role as the only national agency with a legislative mandate to provide specialized corrections services to State and local corrections agencies. It also is worth noting that, although NIC's constituency and the breadth of its responsibilities have increased significantly over the last decade, NIC has continued to provide high-quality services with an annual budget that has remained at approximately \$10 million throughout the period. NIC has accomplished this through considerable fiscal responsibility, innovation, and expertise,

often times pooling resources with other Federal agencies to provide maximum benefit to State and local corrections. While the Bureau of Prisons has benefitted greatly from all of these qualities, it is clear from the feedback we receive that State and local corrections agencies have been greatly aided by NIC's assistance and continue to look toward NIC to help them develop strategies that successfully address their corrections needs while maximizing the use of State and Federal resources.

#### CONCLUSION

I would like to conclude by commending the staff of the Bureau for the job they continue to perform under the difficult circumstances that have resulted from our tremendous growth and change in the inmate population. I consider it an honor to represent all Bureau of Prisons' employees before this Subcommittee today.

This concludes my formal statement, Mr. Chairman. I would be pleased to answer any questions you or the other Members of the Subcommittee might have.

Mr. MCCOLLUM. Well, thank you very much, Dr. Hawk.

I do have a few questions and I would like to see if I can get the 5-minute timer going here because I'm going to apply it to myself, and we'll probably have two rounds of questions, if it doesn't take too long this morning, because there are a lot of things that we could discuss with you.

I'm curious to know how many new facilities you expect will be needed over the next 10 years in the system, if you have such an estimate.

Ms. HAWK. Our population projections carry us out through the year 2000, and somewhat out to 2002 and a little beyond that. We feel that's probably the best projections that we can make since Congress changes the laws every once in a while.

Mr. MCCOLLUM. Well, we do, that's true.

Ms. HAWK. But our projections right now indicate that, of the institutions that we already have moneys appropriated for—and that's roughly about another 18 institutions that will be coming on-line in the course of the next 3 years—we will have our crowding level down to 7 percent over our capacity by 1998. It then starts moving back upward again to roughly being at about 20 to 30 percent overcrowded again, if we build nothing more other than what's already appropriated for in the 1996 budget. We'll be moving back upward again after we hit the year 2000. So we're projecting that we will probably be needing some more institutions other than those already funded as we move out to the year 2000 and beyond.

Mr. MCCOLLUM. Who builds Federal prisons?

Ms. HAWK. Private contractors.

Mr. MCCOLLUM. What kind of directions are they given? Do you have a bidding process? How does it work?

Ms. HAWK. Yes, sir, we follow all Federal requirements on our construction. First, we identify the sites. We go into communities and identify an appropriate location for a prison to be. Once we have the support of the community, we then follow the requirement of the Federal Government which necessitates an environmental impact statement. We identify the site that we are interested in, or multiple sites that we're interested in, and then we go through the environmental impact study. Once that is completed, we then go out to an architectural firm, through the proper bidding requirements, and select an architectural firm who designs the facility. We then go out on a major construction bid for the large part of the project, and the private sector contractor builds the facility.

Mr. MCCOLLUM. What's the average length of time it takes from the date a contract's awarded until you actually have a facility open? Do you have an idea?

Ms. HAWK. From the day at which the construction contract is let, it's basically 18 months. We envision that we'll be in it within 18 months of the construction contract being let.

It usually takes us a few years to get an institution operational, from the time at which we first start siting a facility. The environmental impact study takes approximately a year or so to be completed. The law requires that all of the environmental impacts that could be identified for the community are thoroughly explored before we make a final decision of siting. We then go to the architectural firm. Whether we're building an institution from scratch; that is, we don't have one designed yet; or whether we're simply modifying a design, and since we've been building a fair number of them lately, most often we're simply modifying designs—

Mr. MCCOLLUM. Sure.

Ms. HAWK [continuing]. And fitting them to the new footprint that they're moving into; the length of time varies depending upon how complex the task. And then once the construction contract is let—and there are some timeframes that are utilized in our announcement of the bid—companies coming in and bidding on the contract, and then the awarding of the bid—then it's about 18 months from that point forward to have it up and running.

Mr. MCCOLLUM. Well, is one company usually awarded a single contract for everything including design or does this sometimes go to different companies?

Ms. HAWK. No, we have looked at that as an option and we are going to be doing that in one of the new institutions we have coming forward. It does not appear to us today that there are significant savings in going with one singular contract or with carving the contract up. The piece that entails the largest amount of money is going to be the construction contract.

Mr. MCCOLLUM. Sure.

Ms. HAWK. The architectural portion and the others really are not very significant in terms of the cost, but we are realizing that there may be some potential savings and perhaps some efficiencies in going with a singular contract. So we are going to be doing that with our new institution that we're planning for in Hawaii.

Mr. MCCOLLUM. Well, now is the firm or whoever does the environmental studies always going to be different? Is that a specialty item that you have to contract out or is that done in-house somehow?

Ms. HAWK. We contract them out. We use the Army Corps of Engineers to initiate some of the work with us, but most all of the elements along the way are contracted out to the private sector, and we use private sector companies to help us manage the contracts. We have certainly used the private sector along the way to make prison construction as cost-effective as possible.

Mr. MCCOLLUM. Do the—

Ms. HAWK. But we do believe we have the responsibility of insuring, when Congress gives us millions of dollars to build a facility, that we maintain some level of control over the activities that are going to be handed over to the private sector.

Mr. McCOLLUM. But do you competitively bid these various contracts?

Ms. HAWK. Yes, sir, we do; absolutely.

Mr. McCOLLUM. Do the contractors guarantee cost overruns in the construction contracts?

Ms. HAWK. I believe that they do, sir. I would say with almost full certainty they do.

Mr. McCOLLUM. I have expired my 5 minutes, but I want to ask you one other question on construction and then I'll try to limit myself so that I don't let other people have a bad example.

What's the average square footage in a Federal prison cell?

Ms. HAWK. The average square footage in our cells we're building right now is approximately 80 square feet, and they're all to be double-bunked, so the square footage per inmate is about 40 square feet. We actually fall below the American Correctional Association standards right now with the square footage that they indicate should be available. We have moved in the last several years, Mr. Chairman, as I know you're aware, to the double-bunking standard.

Mr. McCOLLUM. Right.

Ms. HAWK. Most States use a single-bunking standard, but we realized there were significant efficiencies to be had by double-bunking all of our minimums, all of our lows, the vast majority of our mediums, and our highs. And right now all of our institutions are double-bunked all over the place because we're still overcrowded.

But what we build for is 80 square feet per cell with two inmates in a cell, which comes out to about 40 square feet per inmate.

Mr. McCOLLUM. Well, I know my State and some others have constantly said to me, look, we're being held by Federal courts to a higher standard, more square footage than the Federal prison system uses, and, consequently, we don't understand why judges are doing that to us type of thing, and—

Ms. HAWK. One of the—

Mr. McCOLLUM. Yes, go ahead.

Ms. HAWK. I'm sorry. One of the differences I think in what's happening with some of the States is that the square footage normally only applies to the living space, the bed space, where inmates sleep. Where we've been able to avoid court orders or litigation on conditions of confinement is, even though our housing space is very, very crowded and we have people stacked on top of each other, what we do manage to protect are our service areas, so that we have adequate health care space available, adequate space for food service and the required services. So the thing that's enabled us to avoid court order is not our bed space—in fact, right now we're the second most crowded correctional system in the entire country in terms of living space, but we have program space available, activities available, service area space that is adequate for the inmates, and that's how we've managed to not—

Mr. McCOLLUM. Who's the most crowded? Now you've begged the question. Who's more crowded than you are?

Ms. HAWK. Ohio.

Mr. MCCOLLUM. OK. And, last, is it the States getting in trouble over these other service areas? Is that where you see that litigation?

Ms. HAWK. That's where most of the courts get involved. Crowding in and of itself is not always the issue. The issue is whether or not inmates have access to the services that are essential—food, health care, safety, and sanitation.

Mr. MCCOLLUM. I yield to the gentleman from New York.

Mr. SCHUMER. Thank you, Mr. Chairman.

I'd like to ask you about drug treatment in the prisons, something of great concern to me. Last year's crime bill mandated drug treatment for all Federal inmates who needed it. Could you tell us how that's being implemented? What are two or three points of progress and where are some of the difficulties that you've experienced?

Ms. HAWK. Yes, sir. We are meeting, in 1995, the 50-percent requirement, and if our funding comes forward in 1996, as we anticipate that it will, we'll have no problem meeting the 75-percent requirement in 1996. We have over 3,000 residential intensive drug treatment beds available at 34 institutions around the country. In addition to the residential beds, we offer drug education for every single inmate that comes into the Bureau of Prisons. That's a 40-hour program that takes those individuals that indicate that they may have a need for drug treatment and really tries to educate them, motivate them, encourage them, get them willing and interested in getting involved in drug treatment, so that they will become part of the program.

We have put over 10,000 inmates through our residential drug program since it started in 1990, and we have put probably 60,000 inmates through the drug education programs.

Mr. SCHUMER. Right. On the 10,000, on the more intensive program, how long does it last for the average inmate and have you done any studies to examine the recidivism rate, both for those in prison and then for those who are released and out of prison?

Ms. HAWK. It's a 500-hour program within the institution, and that ranges from 6 months to 12 months. We have a couple of different variations.

Mr. SCHUMER. It uses the therapeutic community approach?

Ms. HAWK. It uses the therapeutic community approach. They're all residential. In addition, a critical part of the program that we added is our transition component. We require that the inmates be released through a halfway house and also spend 6 months in intensive drug treatment in the community.

Mr. SCHUMER. Very good.

Ms. HAWK. We link to a community program because we've found in past years—

Mr. SCHUMER. No question.

Ms. HAWK [continuing]. That's where our failure was. We didn't link residential drug treatment participants well into the community—

Mr. SCHUMER. True of most of the State systems, too.

Ms. HAWK. Yes.

Mr. SCHUMER. You do it in the prison if you don't provide a path out. Have you done any studies to examine recidivism?

Ms. HAWK. We're working very closely with the National Institute of Drug Abuse, NIDA, who has committed to us to do the research on this program. It's a little early for us to make real strong statements—

Mr. SCHUMER. Right.

Ms. HAWK [continuing]. As to the outcome. By next summer, we will have enough inmates who have made it successfully through the program, through the transition phase, as well as have been on the street for a sufficiently long enough period of time to really be able to speak with conviction about the impact of our program. But we're very optimistic. Initial findings make us very optimistic that it is having an impact.

Mr. SCHUMER. Right. I'd like to ask you to examine both the recidivism rate in terms of committing another crime and being resentenced either at the State or Federal level, and, secondly, the recidivism rate in terms of lapsing back into drug abuse. I think those are important.

I understand you're not going to do a study until 5 years after it's started, but you said indications are it's successful. Could you give us a little more detail?

Ms. HAWK. Right. The studies have been ongoing since the program started—

Mr. SCHUMER. Right.

Ms. HAWK [continuing]. And we're tracking the inmates as they come out. We just don't have enough of them yet out and on the street long enough to speak with conviction.

Mr. SCHUMER. What does long enough mean, about a year?

Ms. HAWK. We anticipate closure in about a year and then being able to speak with some real confidence in our findings, but so far we believe that we're seeing some real progress being made in the factors that you're talking about, both in terms of getting involved in drugs again and also in terms of staying on the streets and not reoffending.

Mr. SCHUMER. Right. For the more intense program, what's your cost per year per inmate, your marginal, your additional costs?

Ms. HAWK. I've not broken it down by that. I know the total program costs us \$21 million a year, but we can break down the residential program—

Mr. SCHUMER. Could you just submit that for the record? It's probably no more than \$3,000 or \$4,000, I suppose.

Ms. HAWK. Not when you multiply it across all the annual stuff. [The information follows:]

Rep. Schumer requested that the Bureau of Prisons include the outcome indicator of returning to drug use, as well as recidivism, in its analysis of our drug treatment program.

Response. The Bureau of Prisons will include both of these outcome measures. The Bureau will also include measures such as disciplinary actions taken against releases while on Federal supervision, as well as any technical violations of supervision. Additionally, the research will include positive indicators such as a stable work situation, involvement in education or vocational training, and continued involvement in substance abuse treatment.

In answer to Rep. Schumer's specific question about the cost per inmate for the Bureau's residential substance abuse treatment program, that cost is approximately \$2,500 per inmate per year.

Mr. SCHUMER. OK. Thank you. Thank you, Mr. Chairman.

Mr. MCCOLLUM. Mr. Buyer.

Mr. BUYER. Thank you.

One comment that I'll make and I have a question. I was reading in your statement on page 4, you're talking about the drug offenders. I'll agree with you that the Federal population took a real transformation with regard to how many more drug prosecutions we were having and the line. Your prison population was a flat line for a lot of years, and all of sudden it begins to go up from the flat line to an increase because of all of the drug cases.

When I read your statement in here, you talk about from 1984 "about 30 percent of our sentenced population were convicted of drug offenses. Currently, over 61 percent of the Bureau inmates are serving sentences for drug offenses\*\*\*we expect by the year 2000 to be a little more."

But we had a hearing not long ago, and in that hearing, to my surprise, we learned that there was like a 26-, 30-percent decline of drug prosecutions by the Clinton administration. So when I look at these numbers, I might want to say, well, yes, it looks like it's going to continue to rise, but you're riding some numbers from other administrations—

Ms. HAWK. Absolutely.

Mr. BUYER [continuing]. When it comes to you. So I guess what we have here is the flat line for years, and then we've got all these drug convictions, and then we've got a little flat line, and then maybe it will increase some more. But do you want to—do you agree with my comment?

Ms. HAWK. A great part of what's driving those numbers, as you're suggesting, is the inmates that are already with us—

Mr. BUYER. Right.

Ms. HAWK [continuing]. Because the average length of time that a drug offender serves has more than tripled in the Bureau of Prisons in the last few years. So we still have a large number that we're going to keep. So even if the incoming numbers are a little less, 26 percent less, than they used to be, it's still going to cause the population to go up.

Mr. BUYER. It's still—I agree with you. I agree with you. OK, thank you.

The one question I had, Mr. Chairman, really is about some health care, and I have some degrees of ignorance here. So go slowly with me.

When you made a comment with regard to your health care costs are a little bit more than what you're going to find in the general population—did you say that?

Ms. HAWK. We're saying that the level of health that an individual has when entering into one of our institutions is usually less than the level of health that the average population has because of years of drug abuse, or the fact that they're from foreign countries. Our costs, though, are not above costs of health care in the community. Our average cost per inmate for health care last year was \$3,200. The average cost in the community is about \$3,300. That's \$3,200 versus \$3,300. But added into our \$3,200 are all of the costs associated with correctional facility: security costs, the equipment costs, the cost of transporting inmates out into the community, which requires extra staff and overtime, and the cost of transporting inmates to our major medical referral centers. So it's

not just the actual medical care that we're providing. If you just count the medical care that's being provided, it comes out to about \$2,500 per year per inmate. Now that doesn't mean that every inmate in our system gets \$2,500 worth of care a year. Some of them are very healthy.

But what we do have in our system, as I mentioned earlier, is a lot of older inmates with a lot of cardiac disease, a lot of coronary disease. We have a number of AIDS patients, 46 inmates died of AIDS in our system in the last year. We have roughly 1,000 inmates that are HIV-positive. We had 74 births in our institutions last year. So it's the exceptional health care cases that actually drive our costs up, but the average cost is still significantly below that of the average American.

Mr. BUYER. Do you do HIV/drug testing in the prisons?

Ms. HAWK. We do HIV testing. We don't do it on every single inmate that comes in. We do it on roughly 25 percent of the inmates across the system.

Mr. BUYER. If they're—

Ms. HAWK. We test anyone that has any possible symptoms, or history of drug use, or history of homosexual activity, any of the indicators—

Mr. BUYER. Yes.

Ms. HAWK [continuing]. We test those individuals also.

Mr. BUYER. All right. Are they moved or are they segregated from populations or not at all?

Ms. HAWK. They're mainstreamed in our population, as is any other inmate. Nothing different occurs for them unless they become very symptomatic and really develop AIDS, and then oftentimes we transfer them to our medical referral centers because their health is such that they need more intensive medical care.

Mr. BUYER. All right. We're going down a line in questioning I wasn't going to go into, but my question deals with—now here's where my ignorance comes in—is the issues of copayment, whether or not there's abuse or overutilization and controlling of costs and those kinds of things. And if someone ends up in a Federal prison do we try to get judges to say you're going to pay for part of the costs? I don't know. Help me here. What happens?

Ms. HAWK. Well, we do have a cost-of-incarceration requirement that is in previous appropriations language. It's also a requirement of the Sentencing Commission that for any inmate coming into Federal prison, the judge is supposed to make a determination of whether or not they have the ability to pay any part of their cost of incarceration. If the judge does make that finding, then our cost-of-incarceration fee does not come into play. But if the judge has not made that finding, then we can now require the inmate to pay. Rather than nickel and diming the situation the way some States are doing—in terms of paying for a service, you pay for each visit, we believe that could create a real logistical nightmare in terms of collecting costs—the decision was made to go for a one-time flat upfront cost that an inmate pays for the first year of his or her incarceration, which would cover everything. It would actually cover a lot of these health care costs over time.

Mr. BUYER. The last question, real quick, Mr. Chairman, is: In your comparison of the health care costs with regard to your Fed-



eral facilities in comparison to those that have been privatized, would you tell me the difference between the two with regard to your health care?

Ms. HAWK. Yes, it's very difficult sometimes to make a comparison between our costs and the private sector costs. There are a lot of companies across the country providing health care to State systems and local systems, and the prices vary a lot because oftentimes there are hidden costs that they don't include in the upfront cost. For example, if they charged \$2,000 for health care, usually that doesn't include the security costs or it doesn't include catastrophic medical care costs. Most private companies put a cap on how high they will pay, such as a \$25,000 or \$50,000 cap, and anything above that the correctional system has to cover the additional costs.

We've looked at a lot of health care companies cross the country, because if you can find a cheaper way to do it, believe me, we are very invested in doing it the most cost-effective way as possible. But we have to weigh two factors: one is cost and the other is quality of care.

This committee has been concerned in the past about the quality of medical care we provide for our inmates. There were hearings a few years ago, with some challenges raised in terms of the quality of care we were able to provide, and this committee, I believe, made it very clear to us about the quality of care they were expecting us to provide. And that's not a luxurious quality of care but a basic, healthful quality of care.

The General Accounting Office has come in and done studies of our medical program, and I'm sure they will be testifying on that later this morning. And they criticized us in some areas where they did not feel that our quality was quite what it needed to be, and we've improved significantly in this area.

We have not yet been able to find a private sector company who is able to provide health care to our institutions that is both at a cost-effective price that includes everything and not is kind of a hidden cost in that it says they'll do it for \$2,000, but then they turn around and will only cover a \$20,000 major medical when, obviously, our AIDS cases and our coronary care cases and a lot of those, they're the ones driving our health care costs, but also that can meet the quality of care.

One of the things GAO criticized us on for a few years was that we were using unlicensed medical graduates instead of certified physician's assistants to provide a lot of our medical care. Now OPM allows us to use unlicensed medical graduates, but GAO said that did not meet the community standard to which we were being held. I will assure you there is no company out there that's able to provide health care to a State prison system for \$2,000 a year if they are being held to a standard where their major health care providers have to be certified physician's assistants or physicians.

So it's a matter of making choices between not only cost, but also the quality of care that this body and the public is going to expect of us. It's a matter of weighing both of those factors.

Mr. BUYER. All right, thank you, Dr. Hawk. Thank you, Mr. Chairman.

Mr. MCCOLLUM. Mr. Scott's just walked in, so I'll go to Mr. Coble.

Mr. COBLE. Thank you, Mr. Chairman.

You mentioned double-bunking. Now double-bunking does not—is not featured at Marion, is it?

Ms. HAWK. No, Marion and our new super maximum security facility at Florence, CO, are the only institutions——

Mr. COBLE. OK, except——

Ms. HAWK [continuing]. That we usually reserve single-bunking——

Mr. COBLE. Except for those two double-bunking?

Ms. HAWK. Yes.

Mr. COBLE. OK. Well, FPI, as you know, I represent a district that is rich in textiles and furniture. I'm all for FPI, Director, but I'm very concerned about FPI extending its tentacles into the private sector that may damage my textile and furniture people. Tell me where we are on that.

Ms. HAWK. I fully understand your concern, Mr. Congressman, and I assure you that, if we feel any need to move any further into furniture or textiles, we will absolutely abide by the guidelines process that was enacted by Congress, which requires that if we want to move any further into any industry that we're in already, we have to go through a hearing process. The private sector comes in and raises their challenges. And if we cannot demonstrate that our moving into that area any further can be done without hurting the private sector, then we do not proceed any further. So there are real limitations on us and protections for your constituents and any of the companies for which Federal Prison Industries has similar products or services.

That's exactly why we've diversified into over 150 different products and services in Federal Prison Industries. No private business that wanted to make a profit would ever be making over 150 different products, but we do that specifically because we do not want to encroach upon any particular private industry to any harmful degree.

Mr. COBLE. Well, you and I have discussed this in detail previously, and I just wanted to renew it again today, and I thank you for being sensitive to my concerns. I'm sensitive to yours because I appreciate the importance of rehabilitation, of training inmates to better enable them to be self-sufficient when they're released.

Some years ago, Director Hawk, in the midst of the base closing exercise, I raised the issue with your predecessor about what appeared to me to be the desirability of utilizing existing military bases that were scheduled to be closed as prison facilities. Now I realize it would be difficult to use those facilities as a maximum security. That could not be done, but I can certainly see where minimum security, to use the old adage—the infrastructure is in place. Now, granted, they're probably not palatial, but I don't think they should be. So talk to me about that. Where are we on that?

No. 1, have many of those military facilities been utilized to that end?

Ms. HAWK. Absolutely, sir. We have probably over 20 of our 80 institutions that are on former military property. In more recent years, one of the really dramatic ones that we've been able to ac-

quire is Ft. Dix in New Jersey. We now have a capacity for 3,600 inmates at Ft. Dix, where we took the old military barracks, that the inmates now live in, and we put fences and secured them up a little bit. At a cost of only \$10 million, we acquired 3,600 low security beds. We have a step up in security level from minimum security to low security at Ft. Dix.

Two wonderful acquisitions we've gotten recently include the medical facility at Carswell Air Force Base in Ft. Worth, TX, a full medical hospital. We've been able to convert that, as well as some other structures there, for our female population. It's now become our medical and psychiatric facility for female inmates. We're also getting the medical facility at Ft. Devens, MA. It's going to provide a wonderful medical facility for our male inmates. Duluth, MN, is a former medical facility. Leavenworth, is an old military facility. Big Spring, TX, is another. We have a number of them. Eglin Air Force Base is still another.

We also have some that colocate. If a military base downsizes and they don't need the whole facility, what we do is we move into the portion that they don't need anymore. That has double benefits. We gain the benefit of the infrastructure that the military has present, which is very cost-efficient. We also, then, can allow minimum security inmates to work on the military base. So the military gets the benefit of very inexpensive labor to do a lot of the work around the facility that just needs to be done and they don't have the people to do it.

Mr. COBLE. Well, I'm——

Ms. HAWK. We have really made major, major inroads at the military bases.

Mr. COBLE. I'm pleased to hear this. And pardon my pride in authorship, but it was I who was one of the first to suggest that, and I'm glad to see that's taken hold.

If you could, Director, could you give us or me, and the rest of the Members if they want it, the list of facilities that have been so utilized?

Ms. HAWK. Absolutely, sir.

Mr. COBLE. I would be appreciative to you, if you could do that. [The information follows:]

BUREAU OF PRISONS' PAST USE AND PROPOSED FUTURE USE OF CLOSED OR CLOSING  
MILITARY BASES AS FEDERAL PRISONS.

Attached is a document which displays the Bureau of Prisons' past and proposed future use of closed or closing military bases.

**FEDERAL BUREAU OF PRISONS  
FACILITIES ON CURRENT OR FORMER MILITARY BASES  
(JANUARY 1995)**

TABLE I. FEDERAL PRISON FACILITIES ON ACTIVE BASES.

<u>INSTITUTION</u>	<u>MILITARY BASE</u>	<u>YEAR OPENED</u>	<u>POPULATION 1-5-95</u>
1. Federal Prison Camp Eglin, FL	Eglin Air Force Base	1962	816
2. Federal Prison Camp El Paso, TX	Fort Bliss	1989	439
3. Federal Correctional Institution	Fort Dix	1988	2,931
4. Federal Prison Camp Montgomery, AL	Maxwell Air Force Base	1930	942
5. Federal Prison Camp Millington, TN	Memphis Naval Air Station	1990	496
6. Federal Prison Camp Nellis, NV	Nellis Air Force Base	1990	494
7. Federal Prison Camp Pensacola, FL	Pensacola Naval Air Station	1988	520
8. Federal Prison Camp Seymour Johnson, NC	Seymour Johnson Air Force Base	1989	582

**FEDERAL BUREAU OF PRISONS  
FACILITIES ON CURRENT OR FORMER MILITARY BASES  
(JANUARY 1995)**

**II. FEDERAL PRISON FACILITIES ON DEACTIVATED BASES OR FORMER MILITARY PROPERTY.**

<u>INSTITUTION</u>	<u>BASE</u>	<u>YEAR OPENED</u>	<u>POPULATION 1-5-95</u>
1. Federal Prison Camp Federal Correctional Institution (Low) Allenwood, PA Federal Correctional Institution (Medium) Allenwood, PA U.S. Penitentiary (High) Allenwood, PA	Pennsylvania Ordnance Works	1952 1992 1993 1994	809 1,138 1,114 834
2. Federal Correctional Institution Bastrop, TX	Camp Swift	1979	1,237
3. Federal Correctional Institution Federal Prison Camp Big Spring, TX	Webb Air Force Base	1979 1992	1,020 164
4. Federal Prison Camp Boron, CA	Boron Air Force Radar Station	1979	561
5. Federal Correctional Institution Federal Prison Camp Butner, NC	Camp Butner	1976 1992	799 130
6. Federal Correctional Institution Federal Prison Camp Dublin, Ca	Camp Parks	1974 1990	1,100 295
7. Federal Prison Camp Duluth, MN	Duluth Air Force Base	1983	617

INSTITUTION	BASE	YEAR OPENED	POPULATION 1-5-95
1. Federal Penitentiary Institution Federal Prison Camp El Paso, TX	Fort Bliss	1934 1960	1,600 280
2. Metropolitan Correctional Center Guantanamo, CF	Fort Buchanan	1994	963
3. U.S. Penitentiary Federal Prison Camp Leavenworth, KS	Fort Leavenworth	1900 1960	1,440 423
4. *U.S. Penitentiary, CA *Federal Correctional Institution *Federal Prison Camp, CA	Vandenberg Air Force Base " " " " " " " "	1959 1970 1991	1,380 939 306
5. Metropolitan Correctional Center Federal Prison Camp Miami, FL	Naval Air Station	1975 1992	1,199 287
6. Federal Correctional Institution Federal Prison Camp Petersburg, VA	Fort Lee	1934 1978	1,178 344
7. Federal Correctional Institution Terminal Island, CA	Terminal Island Naval Station	1938	1,163

\* U.S. Penitentiary, Federal Correctional Institution and Federal Prison Camp Lompoc are adjacent to Vandenberg Air Force Base on land leased to the Bureau by the DOD.

FEDERAL BUREAU OF PRISONS  
FACILITIES ON CURRENT OR FORMER MILITARY BASES  
(JANUARY 1995)

III. FEDERAL PRISON FACILITIES CURRENTLY UNDER DESIGN OR CONSTRUCTION ON DEACTIVATED BASES OR MILITARY PROPERTY.

<u>INSTITUTION</u>	<u>MILITARY BASE</u>	<u>PROJECTED TO OPEN</u>	<u>RATED CAPACITY</u>
1. Federal Correctional Institution (Low) Butner, NC	Camp Butner	1996	992
2. U.S. Medical Center, Butner, NC	Camp Butner	1996	763

FEDERAL BUREAU OF PRISONS  
FACILITIES ON CURRENT OR FORMER MILITARY BASES  
(JANUARY 1995)

IV. BASES CLOSED OR SCHEDULED TO CLOSE WHICH ARE UNDER ACTIVE CONSIDERATION AS A SITE FOR A BOP FACILITY.

<u>PROPOSED INSTITUTION</u>	<u>MILITARY BASE</u>	<u>PROJECTED TO OPEN</u>	<u>RATED CAPACITY</u>
1. Federal Correctional Institution Merced, California	Castle Air Force Base	NYD	1,536
2. Federal Medical Center Devens, Massachusetts	Cutler Army Hospital Fort Devens	1997	1,600
3. Federal Medical Center Fort Worth, Texas	Carswell Air Force Base	1995	1,100
4. Federal Correctional Complex Victorville, California	George Air Force Base	NYD	750

NYD: NOT YET DETERMINED



Mr. COBLE. Mr. Chairman, I see my time has expired, and I thank you. I thank you all for being here.

Mr. MCCOLLUM. Thank you, Mr. Coble.

Ms. Jackson Lee.

Ms. JACKSON LEE. Thank you very much, Mr. Chairman.

I noted in your testimony, Dr. Hawk, that you mentioned, I guess, 125 percent overcrowding. Is that overcrowding that is existing today, and how long has that been ongoing?

Ms. HAWK. We're at 125 percent of our capacity today. So we're 25 percent overcrowded. That's actually a significant improvement. We were up to 150 percent of our capacity. And with the assistance of Appropriations from Congress, we've been bringing that number down dramatically.

Ms. JACKSON LEE. How many years have you been in that posture, meaning whether it's been 150 or now at 125?

Ms. HAWK. Well, the population's started shooting up in about 1984. So we've been trying to catch up since about the mid-1980's, with the population coming in very quickly and us trying to build quickly to keep up with the population growth.

Ms. JACKSON LEE. To respond?

Ms. HAWK. Yes.

Ms. JACKSON LEE. Would you be able to determine that the recent legislation dealing with mandatory drug sentences has had an impact on the incarceration rates, and will you be able to maintain the pace with that kind of law enforcement and penalties being attributable to some of those offenses?

Ms. HAWK. The primary growth that we've experienced has been the drug offenders, and it's been a combination of the increased law enforcement emphasis on drug offenders, as well as the mandatory minimum sentences, the removal of parole from the Federal system—we no longer have parole—the significant cutback in our good time that we can offer to inmates, and sentencing guidelines. So it's a combination of all of the factors, mandatory minimum sentences certainly being one of these.

Ms. JACKSON LEE. Have you been able to determine what kind of inmate those drug offenders are? Are they inclined to seek some of the resources, education, or are they inclined to be better behaved or are they—can they be distinguished from the other population?

Ms. HAWK. There's really a wide mixture in the drug offenders. We certainly do have a sizable percentage of the drug offenders who are low-level offenders. They were not major traffickers. They were not sophisticated. They had either no prior record at all or a very minimal prior record, or no commitment history at all. And those are individuals who are very good inmates. They don't cause us problems. They want to get out. They want to do their time as quickly as possible, take advantage of what programs are available, and get out. They cause us few problems.

There's also the group, though, that were the more major drug traffickers in the communities, or international drug traffickers, or traffickers across State lines, oftentimes involved in gangs or cartels, where aggression, firearms, and violence are all a part of their makeup. They have proven to be a very difficult population because many of them have very long sentences and oftentimes very young

offenders. They basically give up hope very early on because they're looking at doing perhaps 20 or more years. It's hard to get them motivated into education or drug treatment when they see getting out as being so very far into the future. So we have different groups of drug offenders.

Ms. JACKSON LEE. OK. Well, that helped me. I think it certainly speaks to what I had expected in how you distinguish those two populations.

Let me conclude my remarks by indicating that I'd like to be in dialog with you with some additional questions, either in writing or further discussion. I noted in the President's budget that he has offered to privatize. There seems to be a new cutting-edge effort. It is certainly one that has been raised in my State, the State of Texas.

Let me ask you pointedly two questions. One, in the proposal of privatization, what kind of efforts will be put forth to encourage minority participation in construction and other aspects of that prison privatization, both from the running of prisons—I know that we have some speakers, one in particular seems to reside near Houston, that is dealing in privatization and the running of private facilities. But what would you do in communities in reaching out to either minority contractors, and how does that work? And then, in particular, I understand and have worked with your office on a center in Houston, the maximum—or the minimum detention center. It might be maximum, if I'm not mistaken. And if you would comment on the cost element—cost element was raised and you mentioned double-bunking, and I think it's important to note, if you make every effort to make those cost numbers be as efficient as possible and for the unit or the unit itself be as effective in its security as possible.

Ms. HAWK. Absolutely. Thank you, yes. In terms of the construction issue, the institutions that are to be privatized in the upcoming years are already built. The moneys were already appropriated. We've already let the contracts. So the Federal Government will own those buildings, but the private sector will run them. As we always follow all Federal requirements, we do make the proper allowances for minority businesses in the entire bidding process for any construction contract.

In terms of the Houston facility, I appreciate your raising that issue because there was confusion in Houston in terms of the cost of that facility. The State had contracted for a facility locally. It was going to cost significantly less than the institution that we were building, and we were being accused of gross overexpenditure of funds, and it really was a situation of real confusion.

The facility we're building in Houston is a high security, pretrial detention facility, much like our Metropolitan Detention Center in New York City, which right now holds the World Trade bombers, some major Medellin cartel members, the really big-time offenders. The State jails that the State of Texas is building right now—and I've had many discussions with their head of corrections, Andy Collins, who has defined for me the State jail system—the jails they are building now in Houston and in Dallas and in other locations are minimum security institutions, not to hold pretrial heavy offenders, but to hold sentenced offenders who are doing 2 years or

less. Their head of corrections referred to them as minimum security facilities, minimum security camp-like facilities, that do not require heavy security. They are open dormitory types of facilities and are very, very different than the pretrial facilities we're building.

Another matter regarding the new State facility in Houston is that the structure is purely bed space. It is located right next to the major Houston jail facility. So the new facility they've built does not have food service facilities available. It doesn't have health care facilities. It doesn't have any of that kind of space in that structure. For all of those services, they'll transport the people over to the other building. So it really is truly a case——

Ms. JACKSON LEE. Whereas the one we're building, the Federal Government has everything——

Ms. HAWK. Ours is a standalone facility. We don't have anything else in Houston. We have to be.

Ms. JACKSON LEE. It's well contained.

Ms. HAWK. It's absolutely contained, all services will be provided within, and it will be capable to hold the nastiest Federal offender that could come into Houston in individual rooms, although they all would be double-bunked. It's not an open-dormitory style facility. So, really, it's very unfair and misleading to be comparing our cost to the cost of the State facility or the one being built in Dallas.

Ms. JACKSON LEE. I thank you, and I'd like to be kept apprised and work with you as that proceeds——

Ms. HAWK. Excellent.

Ms. JACKSON LEE [continuing]. And be able to respond to some of the questions that are being raised. Some have already been answered, and I appreciate that very much. And so I'll look forward to meeting and chatting with you on the issues.

Ms. HAWK. Excellent.

[The information follows:]

Currently, the architectural-engineering firm, 3D International, is completing the first stages of the facility's design. Although the schedule for this project has not been officially established, we anticipate the facility will be activated in 1998.

Ms. JACKSON LEE. Thank you.

Ms. HAWK. Thank you very much.

Ms. JACKSON LEE. Thank you, Mr. Chairman.

Mr. MCCOLLUM. You're welcome.

Mr. Heineman.

Mr. HEINEMAN. Thank you, Mr. Chairman, and I regret that I was not here for your direct presentation, Dr. Hawk, but I want to compliment you on the length and breadth of your responses since I've been here. I just have a few questions.

Do you have in your female penitentiary or facility conjugal visits?

Ms. HAWK. We don't have conjugal visits at any of our institutions.

Mr. HEINEMAN. Any place. So I assume these births that have taken place are in the first year?

Ms. HAWK. Yes sir, or if someone went home on a furlough, which we allow only during the latter years of an inmate's sentence.

Mr. HEINEMAN. OK. What—who takes care of the child? Is that done in-house?

Ms. HAWK. No, we have no capability to hold the children of inmates within our institutions. What we do have available, though, is a program we call Mothers and Infants Together. So if we have a woman that is pregnant and she is a minimum-security or low-security inmate that we can trust out in the community without heavy supervision, we place the inmate in a halfway house setting that's specifically designed for this purpose. Inmates go out 3 months prior to the delivery of the child. They receive parenting skills and child rearing training. They then have the baby and spend 3 months with the baby in the halfway house facility. Then, unfortunately, the baby goes off to someone else.

Usually, the care provider is a family member that is able to care for the baby but we have been able to identify in some of our communities—Lexington, KY, which used to be our major female medical facility and now Carswell, Ft. Worth, TX, which I mentioned earlier—a community group, like a not-for-profit group that keeps the babies in their setting and they bring the babies out on a regular basis to visit with the mothers. We can furlough the mother out for the day to visit with the baby, to really try to establish these bonds between the mothers and the babies, because I think it's a very tough way to start your life, to be born to a mother in prison. I think sometimes that children of our inmates can become our inmates of tomorrow, if we don't do some important things to intervene. So we do what we can for those inmates that are of lower security levels. For those women that are looking at doing a lot of time, it's a lot tougher to keep that bond as strong.

Mr. HEINEMAN. Now one other question about the drug treatment: I read in last year's crime bill proposal—and perhaps it was in the crime bill itself—about drug treatment for offenders in the facilities and the possibility or probability of early release at the termination of their treatment. Is that in effect now?

Ms. HAWK. Right. The 1994 crime bill allows for inmates to be able to obtain one year off of their sentence if they are nonviolent offenders. It does not apply to violent offenders at all. Only non-violent offenders who have a serious drug abuse problem and who successfully complete not only the institution residential program, but also our transition program out into the community, and have no regression in terms of their drug use or any new charges are able to achieve one year off of their sentence.

Mr. HEINEMAN. Were I and my colleague, Mr. Coble, both arrested at the same time for the same crime and got the same conviction and the same sentence, and were I a drug offender and he not, would I not be eligible to get out earlier than he does because I was a drug offender?

Ms. HAWK. Yes, sir.

Mr. HEINEMAN. That is now—that is now in place?

Ms. HAWK. It's in the 1994 crime bill, yes, sir.

Mr. HEINEMAN. I have no further questions, Mr. Chairman.

Mr. MCCOLLUM. Thank you. Thank you, Mr. Heineman.

Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman.

Dr. Hawk, I wanted to ask a couple of questions along the same lines of what we can actually do to reduce recidivism. I noticed in your testimony that for literacy programs you're covering about 40 percent of the available——

Ms. HAWK. Well, 40 percent of the inmates coming to us do not have a high school education.

Mr. SCOTT. How many of those are in educational programs?

Ms. HAWK. All of them are required to be involved in education when they come in to the Bureau. We require 120 days of mandatory education for any inmate coming into the Bureau who does not have a high school diploma or who does not pass the test, even if they have a diploma, but cannot function at our literacy level.

They are able to opt out of that program after 120 days, but what we do is we build in a lot of disincentives and motivations to try to keep them in, so that they're doing it on their own decision rather than us forcing them to. An inmate cannot advance beyond the lowest pay grade level for any job that we have at any of our institutions unless the inmate is still in education. And we have other incentives built in to keep them in.

Mr. SCOTT. So those that want to participate, all of them are able to participate?

Ms. HAWK. Yes. Oh, absolutely. Yes, sir.

Mr. SCOTT. What about prison industries? You alluded to some of those. Do as many people as want jobs, are jobs available?

Ms. HAWK. Yes. We have waiting lists for a period of time, obviously, while new inmates are coming in and other inmates are in the jobs. If an inmate has a very short sentence, a sentence of less than a year perhaps, they may wish to be in Federal Prison Industries but never be able to do so simply because there's not enough work to go around. They would have regular jobs, but they wouldn't be in Federal Prison Industries. But I would say any inmate doing more than a year that has a clean record and is not spending their time locked up for disciplinary reasons certainly has the opportunity to work in Federal Prison Industries.

Mr. SCOTT. You mentioned double-bunking. Do you have any evidence on whether double-bunking increases or decreases recidivism or causes disciplinary problems?

Ms. HAWK. It was the professional judgment of most of us in corrections for many years that at the higher security levels you could not double-bunk inmates without creating problems, where inmates would fight, they would have difficulty, that they needed that space to be separate. What we found, I think, across the system with our forced double-bunking with the overcrowding rates and more and more inmates coming in, we realized that maybe we had been too conservative and that you actually could do a fair amount of double-bunking without having serious ramifications if you made sure, as I indicated earlier, that you provided all the necessary services of health care and food service and you had space for the inmates to get out of their housing areas to recreate or to be in more spacious areas. But the double-bunking in and of itself was not going to create huge problems.

So we changed our standard in the Federal prison system to accepting 100 percent double-bunking at all minimum security and low security facilities, 50 percent double-bunking of our medium se-

curity facilities, and even 25 percent double-bunking at our penitentiaries. We even worked with the American Correctional Association, where they have readjusted their standard of saying that our old professional judgment that you could not double-bunk anything without problems was probably too conservative. So even the national standard has been adjusted so that you can double-bunk in many instances, as long as you provide the other services and the relief for inmates with adequate program area space.

Mr. SCOTT. And you're following this and the numbers are supporting that position?

Ms. HAWK. Yes. Now we have had to go to triple-bunking when double-bunking in some settings was absolutely not acceptable, as I mentioned earlier, when we were up to 150-some percent of our capacity. But coming down to 25 percent of capacity and building the rest of the institutions that have already been appropriated we'll be moving to what we believe will achieve a very doable population level, while still having a fair amount of double-bunking across the rest.

Mr. SCOTT. Weight training, color TV, cable TV, what effect do they have on recidivism and disciplinary problems?

Ms. HAWK. I don't know of any correlation between many of these issues in and of themselves or any studies that have been done to determine the impact between those and recidivism. I do, though, have very strong feelings about many of the things that have been identified as perks and frills, and TV's and cable TV's and some of those kinds of things have certainly been entered into that mix. And I certainly know the discussion on weight lifting.

Let me deal with the weight lifting issue first. The inmates who are involved in weight lifting in our institutions are not the inmates who cause us problems. We conducted a survey after the initial discussion started on weight lifting, and we found across our system that the inmates involved regularly in weight lifting are a much more disciplined group of inmates; they're very health conscious; they're concerned about their physical bodies. Many of them had been drug users and now they are more concerned about being healthful. They're very disciplined. They really have devoted themselves to the weight training programs. They're not the inmates that cause our problems.

We've also found that the weight training equipment is so important to our inmates that inmates don't use that equipment as weapons. We have had, I believe, one or two instances out of 200-and-some where any weight-related item was used as a weapon in any kind of way.

So we are very troubled by the possibility of losing weight training in our institutions. I know there's the concern that these inmates could be bulking up and could then be a threat to our staff or a threat to police. The union, the Council of Prison Locals, who represents our bargaining unit staff, is very much concerned about losing weight lifting in our institutions also and believes that there will be more harm in losing this activity, an excellent activity for inmates to burn up energy and to be devoted to something in a very positive way. They're very concerned about losing it.

Regarding television sets and any of the other recreation activities, you cannot identify any particular one of those and say that

they make or break an institution. But I think a lot of these kinds of things provide us with positive incentives that we can offer. And we don't have individual TV's in rooms. We have maybe one TV to 100 inmates, and they all have to share it. But just access to these kinds of things provide incentives for inmates to want to maintain good conduct to be able to have access to these different recreation kinds of programs.

If all of those kinds of programs were removed from an institutional setting, it would be very difficult for us to have positive programs, activities, or things to occupy time, that is, activities to offer to the inmates to be able to develop responsible conduct. If you have nothing to work toward, if there's nothing more I can take away from you, then how do I encourage you toward positive behavior and responsible behavior? A lot of these things that, unfortunately, get identified as perks or frills oftentimes are things that are basic to us in correctional administration to be able to offer that balance to the inmates so that they want these nicer things—and they're not luxurious anyway, but nicer things—then they have to maintain good conduct because, if they don't maintain good conduct, these things will be taken away from them.

Mr. SCOTT. Thank you very much. Thank you, Mr. Chairman.

Mr. MCCOLLUM. Mr. Bryant.

Mr. BRYANT of Tennessee. Thank you, Mr. Chairman.

Thank you, Dr. Hawk. I had a couple of prepared questions, but I wanted to comment about your last answer.

You articulate very well what I have heard from a lot of folks who handle prisoners, that it helps, in effect, control behavior, and so forth, keep the lid on volatile situations. But the concern I hear most from my constituents and the people who vote me into office is that perception—

Ms. HAWK. Sure.

Mr. BRYANT of Tennessee [continuing]. And it's a different philosophy. I can't say that they're wrong, either, because many of my constituents don't have cable television; some don't have color televisions. Many of them don't have the luxury of laying around the house and lifting weights to bulk themselves up to get their exercise. They have to get out and work in real jobs, 8, 10, 12 hours a day to eke out a living.

And it is concern to them—and I'll be honest with you, to me, too—that we have this situation existing in our prisons. I think we have to do a better job in finding things for them to do and maybe making it more difficult on them, and the end result, it may make it more difficult on our prison wardens and our prison guards to control them, but prisons should not be an easy life. And I understand the rationale that we drifted into these perks, but I'm very much opposed to them and very strongly supported the bill that came out of this committee and this House that would severely limit them. And I realize that it's going to create more work for all of you, but that's what you're there for, and it's very offensive to many of my constituents that people in these prisons have those opportunities that they don't have as law-abiding citizens. And I know you've heard that, so I'll climb off my soapbox and ask you a couple of questions, if I could.

In the area of privatization and converting military bases to prisons, I, too, am an advocate of that, like my colleague, Representative Coble. I would like to have a list, if I could, of those conversions that have been made of the military bases.

[See p. 26.]

Mr. BRYANT of Tennessee. And I've seen the privatization work, more so I think in my district in the area of pretrial people being kept in private prisons on a contract basis. I think that's very economical. And with the prison population in the Federal courts growing and projected growth of 30,000 in the next few years, I trust that your Department is making maximum use of not only the privatization of prisons, but of also contracting out to private prisons to house people.

Ms. HAWK. Yes, sir. We have had roughly 10 percent of our population housed in private or nonprofit settings other than the Bureau of Prisons for many, many years. All of our community corrections offerings are provided by private sector or charity groups. We do not get involved in the community corrections business anymore. We've also had roughly 3,000 or more inmates in private facilities in Texas, private companies that operate prisons for local governments, and we contract with the local government. We also have just contracted a 1,000-bed fully privatized facility in Eloy, in the past year, a facility that is shared by us and INS. The U.S. Marshals Service, INS, and the Bureau of Prisons for a long period of time were the primary users of private prisons around the country. If you looked at any listing of who uses private prisons, the Department of Justice was the primary user of private correctional space all around the country. So this movement into privatization is not new for us; it's more of an extension of what we've already been doing, and we're moving more into the pretrial area, as you suggested. All future pretrial facilities will be privatized, as well as many minimum and low security facilities. So it's really kind of an extension of where we've been.

Mr. BRYANT of Tennessee. OK, thank you.

I also agree with your testimony that the Bureau's primary correctional program is work, and we stress the idea of job skills and training and experience, but I don't want to overlook the other example or the other reasons that we have our inmates working, and that is, in addition to keeping them occupied, ideally, they're not going to be able to watch the television and bulk up on weights.

I have an interesting story that when I was U.S. attorney I used to see in the Marshal's office a poster and the poster showed—it was encouraging the marshals who transport prisoners, who have to put them on airplanes and physically escort them around at high risk in some cases, to go to trial or testify or whatever, it was an encouragement to the marshals to work out because it had the slogan: "And if you don't work out today, guess who is," and it had a picture of a guy in a striped suit lifting weights. So I think the people who work with these folks and transport them have a legitimate concern there with these folks that bulk themselves up, as well as society once they get out, not only the prison guards, and so forth, but society once they get out.

I'm concerned that work also is another way that they can earn money to pay retribution, to pay court costs, to pay restitution to



society. Roughly, what percent of our prison population of able-bodied people actually work?

Ms. HAWK. One hundred percent of our able-bodied population works. Obviously, those with medical problems that prohibit them from working don't; and pretrialers, we cannot by law force them to work. But every other inmate in our institution works an average of 6 to 8 hours a day. They all have job assignments. We only have 25 percent of them in our prison industry program, but any cooking, any cleaning, any plumbing, any electrical work, any construction, anything that's being done in that institution is being done by inmate labor supervised by staff. So every able-bodied inmate in the Bureau of Prisons works.

Mr. BRYANT of Tennessee. Are they all paid or just the—

Ms. HAWK. They're all paid, and the pay varies. The pay scale for inmates doing institution maintenance kind of work ranges from 12 cents an hour to 40 cents an hour, I think, and prison industry jobs are around 23 cents an hour to a dollar fifteen an hour. And we have a required Financial Responsibility Program in the Bureau of Prisons, so that if any inmate owes a fine, restitution, or even just child support or alimony, any court attempt to get money from that inmate, we carve off a portion of the money that they make, or if they just have it in their savings, they are required to pay toward any indebtedness that they have, or we consider that a lack of responsibility. So they're not considered for any pay grade increases, they're not considered for any furloughs or activities in the community when they're getting close to release. We believe that inmates must know that they have to be responsible for themselves and their indebtedness, and we have this required Financial Responsibility Program for every inmate.

Mr. BRYANT of Tennessee. Thank you, Dr. Hawk.

Mr. MCCOLLUM. Mr. Chabot.

Mr. CHABOT. Thank you.

Just a couple of questions. I agree with much of what I've heard you say here this morning and what I've read. As Chief Heineman said, we had some other things going on, so I couldn't be here during the whole testimony.

But one thing I have to say that I have some disagreement is on the weight lifting issue—

Ms. HAWK. Yes.

Mr. CHABOT [continuing]. As I'm sure you probably know. Just a couple of questions in that area.

Are you familiar with the 1994 Riker's Island Prison gymnasium riots—

Ms. HAWK. Yes.

Mr. CHABOT [continuing]. In which 25 people were injured, and in that case the inmates were attacked—or the inmates actually attacked the corrections guard with 50-pound weights?

Ms. HAWK. Yes, sir.

Mr. CHABOT. And have you factored that into your thinking on this issue?

Ms. HAWK. We certainly have, and we've also factored in the death of the correctional officer in the State of Kansas, who was beaten by an inmate with a weight, and I believe weights were also a factor in the Lucasville, I believe, situation—

Mr. CHABOT. Exactly, in my State.

Ms. HAWK [continuing]. In Ohio. And I realize that some systems have had problems with weights. We do not have weights in all of our institutions. At our maximum security institutions, we do not have weights available there. In some of our institutions we do not have free weights. We have the fixed structures, but nothing that you can take apart.

Mr. CHABOT. Well, in fact, in Marion, IL, wasn't—that was a case when they did have weights and a couple of guards were actually killed, and the weights were then taken out?

Ms. HAWK. They weren't killed as a result of the weights, though. They were killed—

Mr. CHABOT. Well, they were killed by the inmates who had bulked up and were there—

Ms. HAWK. Not necessarily. There were a lot of reasons for that lockdown. We did have weights there years ago. They were taken out. But I'm not sure there's a direct nexus between—

Mr. CHABOT. OK. Well, we were told—and I believe it was by some prison folks themselves—that the actual people that were convicted of the murders were inmates that had basically spent years bulking up. So, I mean, they were kind of the epitome of why I and much of the public and many of my colleagues agree that this perhaps is not such a good idea.

Ms. HAWK. I guess the resistance and the disagreement that I have, and I think we in the Bureau of Prisons have, with a weight lifting ban is that it's such a blanket, totally encompassing approach, that you will not have any weight training in any Federal prison. We agree with you, when you look at the Riker's Island situation, the maximum security institutions, and even some high security populations, there's no way in the world I want them having access to weights, for lots of reasons. But my concern is—and I guess what we would like to offer as an alternative to the absolute abolishment of weights—is a more modified approach that allows us as correctional administrators to make some of those judgments in terms of managing our institutions.

We'd like to suggest an alternative that would restrict access for inmates who have not demonstrated that they are responsible enough to handle the access to weight lifting equipment. So that any inmate that's had any misconduct report, any inmate that has a proclivity toward using this activity in a negative way has absolutely no access to it. In some institutions we may begin right off and say that's our entire institution. So we won't even have weights in that facility.

My concern with the weight lifting legislation is that it's so all-encompassing that it takes away every bit of judgment that we might have as correctional administrators to make choices where you're absolutely right and we should not have weight training or we should restrict access to weight lifting but also where we've not had problems at all. It doesn't just allow us to make those professional judgments.

Mr. CHABOT. Of course, there are tremendous difficulties in predicting just which inmates are going to commit the violent crimes either while they're in prison or when they get out later on, and that's the danger. I think they've shown by their behavior in being

behind bars that they are in a group that I would be hesitant to use tax dollars to bulk up and then someday knowing that the odds are they're going to be out on the street again. So that's the concern I have, and that's why I support more an all-encompassing answer to this problem.

Are you also—I assume you know of Ms. Long Wagner, who is also from my State, who was brutally raped by a prisoner who had spent about 7 years bulking up, and within about 8 months of getting out, this individual savagely raped her and she now is one of the leading spokespersons in the country about why we should not allow prisoners to have access to weight lifting equipment. I don't know if you've talked to her or if any of your people have.

Ms. HAWK. No, I have not directly. We had an experience with a contract employee in Atlanta who was brutally raped and murdered several years ago, a female employee. But that inmate wasn't bulked up.

So I think it's difficult to immediately connect that with any access to a weight training program. We would be very willing to limit the amount of weights that could be used and keep it to a toning program, where the maximum amount of weight that can be used just works toward maintaining some sense of self-image on the part of the inmate. You mentioned Marion earlier. We removed all weight lifting equipment from Marion. There's nothing there for strength training at Marion. But if you walked in there and looked at those inmates, you'd see significant upper body strength among these inmates, and it's because they do pushups and they will pull themselves up, when they're on recreation, they'll pull themselves up on door frames or anything to be doing chin-ups. It is absolutely impossible for us to totally prohibit any strength training activity because, even in Marion where we have not had strength training equipment for years, they are using anything they can to do push-ups and pullups to maintain some upper body strength.

Mr. CHABOT. And that's why in this legislation we felt that the legislation was fair, because it did permit a person, if a person wants to do pushups in their cell, if they want to jog around a track, whatever they want to do to stay in a healthy condition, that's fine. That's one thing. But to use taxpayer dollars to provide the most up-to-date type of weight lifting equipment that many of our citizens couldn't afford to belong to a health club or to purchase it or rent it for their home, we're going to allow prisoners who have actually taken something away from society by committing a crime to have access to this equipment, that's where I and many others draw the line.

But I—your testimony has been very interesting. I thank you.

Ms. HAWK. OK. Thank you.

Mr. MCCOLLUM. Mr. Barr.

Mr. BARR. Thank you, Mr. Chairman.

Dr. Hawk, when we talked earlier about capacity, and I read also the information here on double-bunking and the capacity levels at different level institutions, have there been any problems in recent years with Federal judges finding a constitutional problem because of overcrowding or double-bunking? And if so, are these presenting—are these decisions presenting problems for BOP?

Ms. HAWK. No, sir. We have never been under court order in any way from the Federal courts in terms of overcrowding issues, and one of the reasons for that is, even though our housing space was very, very overcrowded, and still continues to be overcrowded, where we have a room that maybe was designed for one inmate that has three or four and there are very, very close living conditions, what we have been able to do—and it's been kind of the philosophy of the Bureau of Prisons for many years—is to build extra space in our service areas, in our food service areas, our health care areas, our program areas. So it gives us that buffer, so that if we do get a significant increase in population or if one institution should be burned down during a disturbance, and we have to then move all those inmates somewhere else, we have the capacity to take in more inmates and still not run into concerns with conditions of confinement, because service area spaces are adequate, by juggling resources a little bit, to be able to keep up with it. So we've been able to avoid court orders, even though we were grossly crowded in living spaces, by ensuring that our essential services to be provided have always been adequate.

Mr. BARR. OK good. Thank you.

Have you had an opportunity—I know we've referred to it in some of the questions this morning—to review H.R. 667, as passed by the House a couple of months ago? This is the Violent Criminal Incarceration Act of 1995, and it—

Ms. HAWK. Especially in reference to its impact upon us, yes.

Mr. BARR. OK. Are there—are there any particular provisions or titles in there that you have a serious problem with that would cause you to recommend to the President that he veto it, if it passes in the form that was passed by the House?

Ms. HAWK. There are some pieces in there that concern me a little bit. One is the weight lifting issue. I believe that's in that particular bill. That's probably the only one that concerns me to a great extent.

The other concern that we have is simply insuring that, if Congress passes bills of this nature that will result in some sizable increase in our population, that they recognize the responsibility, as was mentioned earlier, to make sure that sufficient resources come to us to be able to handle that increased population.

The crime bill right now, taking into consideration the Senate bill, could have some impacts on our population numbers over several years, and I just want to make sure Congress is aware that, if you increase sentences, that increases our capacity, which means we would need the resources to deal with it.

Mr. BARR. OK, but in terms of those provisions, then, that that would directly affect or more or less directly affect the Bureau of Prisons, the only one that presents a particular problem would be the title IV, the enhancing protection against incarcerated criminals and the prohibition on strength training?

Ms. HAWK. Right, and that's just an internal operational concern.

Mr. BARR. OK. The other provisions you think generally could be acceptable?

Ms. HAWK. Yes, sir, again, if the resources come along with it.

Mr. BARR. OK I was somewhat concerned, Dr. Hawk, in reviewing the material you've presented here on health care costs. Accord-

ing to your figures here, the Bureau spends \$3,302 per year on average per inmate, close to the estimated \$3,229 the average U.S. citizen expended in 1993 for health care costs, and you conclude that these costs are quite reasonable. I'm not sure I agree with that. I do understand—I have some familiarity with Federal prisons through my background, and I do know certainly that some—and perhaps even a larger percentage of inmates at any institution, whether it's State, Federal, or local—are going to have more serious medical needs.

But I'm somewhat concerned with the dollar amount that we are spending. It does seem to me high, and I'm wondering if you could explain here on page 28 of your testimony, up in the top paragraph, you say, "Many offenders have longstanding medical and dental concerns." What do you mean by "concerns?" I mean, are we providing medical and dental services to them other than to simply meet emergency needs that might come up that present a health hazard to them while they're in prison?

Ms. HAWK. Absolutely not, sir. We're doing, I believe, what you're suggesting we should be doing, and that is to provide the basic medical care that is necessary to ensure health today. We also have somewhat of a concern for health in the future, especially for the inmates we're going to have for a long time. For example, health care—I mean dental care. Being able to satisfactorily chew food is going to have a major impact upon their digestive system over several years, and we are concerned that we provide not only immediate care to the teeth, for example, that takes care of an immediate problem, but also ensure that they are going to be able to eat food properly over the next several years or we're going to have to spend taxpayers' dollars to treat the digestive problems that result.

But we do not perform any medical procedures that are purely by choice or that are elective. We only perform those medical activities that are required. If you came to us and you had had a hernia for many, many years, well, you're probably going to have that hernia when you get released from us because it didn't create enough of a concern for you to fix it before; we're not going to fix it for you now.

When we talk about the health care problems inmates bring to us, many of these people are drug offenders, as we talked earlier, and those drugs have a significant impact upon their bodies. We have a fair number of inmates on kidney dialysis because they've done such damage to their kidneys. We have many inmates with coronary disease. We have, as I mentioned earlier, 1,000 inmates that are HIV-positive. We had 46 inmates die of AIDS last year.

The average inmate does not get \$3,200 worth of health care, and I should mention that the \$3,200 includes the cost of security surrounding that health care. The average person on the street pays \$3,300 for health care; that's purely health care. We add into our costs all of our guard service costs, our security costs, our transportation costs, if we have to take them out to the hospital, and overtime cost and guard service for transporting inmates to the major medical referral centers. If we removed all of those extraneous costs, our cost per year per inmate would be about \$2,400 or \$2,500 a year.

A single inmate doesn't get that much care. What drives costs are our extreme cases, the 1,000 HIV cases, the 46 that died of AIDS, the ones on kidney dialysis. We had 74 births last year. And obviously, any of those catastrophic—not that birth is catastrophic—but any of those catastrophic activities are what really drives the health care cost up significantly. So when you average it out across 90,000-some inmates, it comes down to the \$2,500 per year per inmate for health care and then the additional security costs.

Mr. BARR. Excuse me. Mr. Chairman, could I ask unanimous consent to ask just one quick followup question?

Mr. MCCOLLUM. Yes, you may. It's granted.

Mr. BARR. I appreciate those figures, the \$2,400 or \$2,500 figure. That would be the net cost of providing medical and dental services—

Ms. HAWK. Right.

Mr. BARR [continuing]. Exclusive of the added security?

Ms. HAWK. Right.

Mr. BARR. How does either that figure or the other one, since State and local officials also in their facilities have to provide security, how do those figures compare to the sums expended for medical and dental services provided State and local inmates at either State or local jail facilities?

Ms. HAWK. They vary a lot across the country. Texas, for example, is connected to the Texas University health care system. So if an inmate has a serious medical problem, that money doesn't come out of the corrections budget; it shifts over and is absorbed by the State health care provider, and many other States and local municipalities have connections to—

Mr. BARR. Has anybody done any study on that that you're aware of, the average cost of providing either State or local medical and dental services to inmates?

Ms. HAWK. I don't believe that there has been done a complete study across the country to determine those costs because they do vary. It's tough to just take a State and have them tell you what their cost is because oftentimes there are hidden costs and variances. And even the private vendors, who are coming in and providing more and more health care, it's oftentimes difficult even to look at the price that they're quoting because some of them include some things and not other things.

I believe that your State of Georgia just recently went to a contract, and although the cost per year per inmate is \$2,400, it's my understanding that there's a \$25,000 catastrophic cap on that, and that the private vendor will only pay up to \$25,000, and if a case goes beyond \$25,000, then the State has to come back and pick up that cost. Well, that, again, that's what's driving our costs, the cases that go above \$25,000. Other private vendors have caps of \$2,000 or \$3,000, or they'll pay for this and they won't pay for that.

So if this committee is really interested in a comparison between our cost, private sector costs, and State and local costs, the General Accounting Office has been tasked by the Congress before to come and look at our health care. I believe it could be very, very valuable to have GAO come in and look at, as I mentioned earlier, both the issue of cost and quality of care, because GAO has done a quali-

tative study on our health care program and made some citations on us. They felt we were not living up to the quality that they believed was appropriate.

This subcommittee had hearings on us a few years ago and questioned the quality of our health care. So I think it's very important that we look both at cost and quality of care, not luxurious quality, but just to ensure that basic health care is being provided. And I would love to see GAO come in, do a very objective analysis across the board, and help us address those two issues. I think that would be very useful to all of us.

Mr. BARR. Thank you, Dr. Hawk. Thank you, Mr. Chairman.

Mr. MCCOLLUM. Well, thank you, Mr. Barr.

I've just got a few followup questions, Dr. Hawk, I need to have clarifications on.

How many closed or closing military bases has the Bureau of Prisons identified for use as prisons to date?

Ms. HAWK. I believe that right now we are sitting on probably 20 military bases or more at present. We're already on Dix; we're already on Duluth; we're already on Carswell Air Force Base; we've already got access to Devens. We're looking at several more in California, George Air Force Base—I believe we're going to have already some funding for southern California to be able to move in and put a facility there, if not a couple of facilities; Castle Air Force Base in California—

Mr. MCCOLLUM. So some of these are already up and operational?

Ms. HAWK. Some are already up and operational; some have been for years. Others, with the more recent base closure acts of the last several years, are relatively new acquisitions and some of these are ones we're just moving on.

Mr. MCCOLLUM. Can you provide the committee with a catalog of these?

Ms. HAWK. Absolutely.

Mr. MCCOLLUM. And what you expect with regard to future projections of operational activities on some of the bases that have been closed more recently, 1991 and 1993?

Ms. HAWK. Yes, Mr. Chairman.

Mr. MCCOLLUM. Thank you.

[See p. 25.]

Mr. MCCOLLUM. Lorton Prison is a subject which some of the Members of Congress have suggested that the Federal Government take over the operation of. Do you have problems if we do that?

Ms. HAWK. Yes, sir, I do, and the Attorney General has come forward with opposition to the idea of federalizing the Lorton facility. There is no question that the D.C. Department of Corrections needs assistance, and we stand ready, as does the National Institute of Corrections, which is a part of our Bureau of Prisons and provides the direct technical assistance and help to State and local corrections. We have ideas of many ways in which we can certainly assist the D.C. Department of Corrections. We believe that the potential of being able to get some of the crime bill money for prison construction may well be able to assist them to replace their antiquated, very bad facilities, many of which they have at Lorton right now, with new state-of-the-art facilities that could certainly im-

prove their operations. Rather than federalizing the entire Lorton complex and making it a part of the Federal taxpayers' responsibility for now and forever, we would much prefer to see a more scaled-back plan. The National Institute of Corrections, at the direction of our Appropriations Subcommittee, is doing a thorough assessment of what needs to occur with the D.C. Department of Corrections—an assessment of what needs to be done. An alternative would be tremendous assistance provided by the Federal Government and the Federal Bureau of Prisons to assist D.C. Corrections, but then have it set so that at a point in time we will be able to back away from that assistance and the District would then be able to maintain its own system.

I'm very concerned that the idea of just fully federalizing Lorton and handing it over to the Federal Government fully is going to create major, major costs for Federal taxpayers for many years to come, and I don't believe that's truly necessary.

Mr. McCOLLUM. Assuming that you don't take it over fully, what about simply providing for the management of it, the direct management of that prison by your system?

Ms. HAWK. Well, there are actually seven facilities at Lorton. It's not just one. They have 7,000 inmates. So any of the discussion of federalizing Lorton means that we would suddenly have 7,000 more inmates in the Bureau of Prisons, and they're projecting that to reach 9,000 in the next couple of years because of some changes they've made in their sentencing structure.

We would be very willing to get very much involved in assisting their management, again, over however many years it would take to get their system up and running effectively, but then see a point in time where we could pull back out of it again. One of the implications that's there that I think is sometimes forgotten when we look at Lorton is the fact that you'd really need to look at the whole parole structure. They have a totally separate parole structure, a totally separate parole commission, while we're phasing out the Federal Parole Commission. They have 5,000 hearings a year over at Lorton for their inmates. The whole court structure would have to be adjusted because we would be having inmates in Federal prisons who would be sentenced under totally different sentencing structures. Some would have good time; some would have parole; ours wouldn't. You'd have a real mish-mash, and I would think if you're going to ultimately federalize it, you would want to go in and totally revamp the court structure, the parole commission structure, and all of that. You can't look just at who owns the—

Mr. McCOLLUM. That's a good point.

Ms. HAWK [continuing]. The convicted bodies. You really have to look at the entire criminal justice structure in the District.

Mr. McCOLLUM. Well, your point is well made. I just—I asked that because there's a lot of pressure to do that right now. We're going to have some hearings very shortly on the problems of crime in the District of Columbia.

Let me ask you just one or two followup questions related to prison construction. I think everybody's gone over everything else, and I've asked you a lot of them, but there is a witness coming up who has made some interesting points and raised some questions that



I would like to have you address. Some of this may be things that you need to simply provide us information on down the road.

One of the suggestions he's making relates to double-bunking prisoners in the Federal prisons. I assume you do have some prisoners who are single-bunked; is that correct?

Ms. HAWK. Well, I had the opportunity to review the witness' testimony, sir, and I think, unfortunately, there are several inaccuracies or misinterpretations or misunderstandings in terms of our policy, because I realize they suggest that we have single-bunk cells at 100 square feet and a comparable State has 54 square feet. We don't have any cells in the Bureau of Prisons, any single cells for 100 square feet. The ones we're constructing right now or the ones we've had for quite a while have never exceeded 90 square feet. And none that I know of were ever even contemplated for single cells. But our standard right now is 80-square-foot cells to be double-bunked, which is 40 square feet per inmate. So I think there is some confusion in the numbers that he's presenting—

Mr. MCCOLLUM. You don't anticipate, though, ever going away from double-bunking and having those as single cells?

Ms. HAWK. Well, in our super maximum security facilities in Florence, CO, and Marion, IL, we will not double-bunk those because those are the worst of the worst inmates. Our rated capacity, our ideal, for our penitentiaries is to double-bunk only 25 percent of the cells in those facilities, not double-bunk all of them. Well, I know in the lifetime of my career, and probably my successor's career, I don't know that we're ever going to have enough high security cells to be able to provide single cells for all high security inmates, if very many, because—

Mr. MCCOLLUM. So what you're really saying is that, even though ideally you would single-bunk and there may be some paperwork about it at 80-square-foot per cell, the reality is you're double-bunking and you, for the foreseeable future, are going to continue to double-bunk?

Ms. HAWK. But, in fact, when we build our medium security institutions right now—and I go around the country and visit them—even though our rated capacity plan says, ideally, we will only double-bunk 50 percent of the cells in our mediums, when I go to visit those institutions, they already have two beds in them and some of them have three beds and some have four beds in them, because they know reality is we are never going to achieve more bed space than we have inmates.

Mr. MCCOLLUM. Well, one of the things that the witness recommends, if you've read the statement, is to ask the Bureau if the Bureau utilizes a consolidated soups-to-nuts RFP for the facility bids in construction, and I just wondered if you do. He asked me to ask you that; I think I will. I might as well.

Ms. HAWK. If that's the suggestion, that we have a single contract for the architectural work and all of that, as I indicated, our plan is to do that with our new facility in Hawaii. For many years we looked at it in lots of ways and didn't really see any real benefits, because the private sector does all of that for us anyway, and we're going to pay for all of it anyway, and we didn't see any real significant value in putting it into one pot versus carving it up and giving out lesser pieces. If you're unhappy with the architect, you

can move them out of the way and move on with the construction contract, but we believe that there may be some value in that, and so we're going to move toward that at our Hawaii facility.

Mr. MCCOLLUM. OK. With regard to one of the other things he makes a point on, he suggests that you are by far—that is, the Bureau of Prisons—the largest provider of square footage per inmate in the correctional facility development community; that is, not per bunk or cell, but overall. Is that accurate?

Ms. HAWK. Well, that's the comment that I was speaking to earlier, and I don't know that we're the biggest. We do have a philosophy, as do several other systems in the country, that you control your square footage space for the inmates in terms of housing, because that's a major cost. But we have always added a little extra space to our program areas, our work areas, our health care areas, our food service areas, for exactly the reason I mentioned earlier, because that's what enabled us to suddenly absorb the huge influx of inmates that we got from 1984 on and did not find ourselves under court order.

We have never been in a situation in the Bureau of Prisons where we have had to release a single inmate because we didn't have room for the rest of the inmates coming in. Some of our State counterparts have found themselves in that situation. We believe it's a very cost-effective use of taxpayers' dollars to add a little extra space in the front end, which when you factor it out over the life cycle of that institution, is very, very inexpensive when you realize the tremendous flexibility it gives you in use of that institution over time. That has been the philosophy of the Bureau of Prisons for many, many years. It's one that normally we're very much applauded for because it gives us that flexibility to increase our population, change missions, whatever it might take to get the job done, without incurring extra costs down the road.

Mr. MCCOLLUM. One of the other questions that I asked you about a little bit earlier, also again referring to this particular testimony, was whether or not you had any guarantees against project cost overruns. You don't have to answer that here today because you didn't have an answer to it, but I'm curious, if you would provide us that, and if we don't have guarantees, why we don't.

And the other point he's making, he says that in the business they do, they guarantee an agreed-upon construction schedule and are assessed penalties. Does the Bureau of Prisons do that?

Ms. HAWK. Yes, sir. I don't want to speak for absolute certainty here because I would rather come back to give you an answer for sure, but I know in some of the instances where we have run over, they have been forced to pay, but I'm not sure if that's a blanket guarantee or if that's by contract, but let me get that information—

Mr. MCCOLLUM. If you could give us that general information—you know what we're talking about in his area.

Ms. HAWK. Sure.

Mr. MCCOLLUM. I don't think that the witness intends necessarily to be provocative, but this issue is part of an ongoing discussion that we've all been having, as you know, about what we can do to improve our construction efforts, and I just would like to get at the root of that.

[The information follows:]

INFORMATION CONCERNING CONTRACTOR GUARANTEES AGAINST COST OVERRUNS,  
AND ASSESSMENT PENALTIES IF SCHEDULE IS NOT MET

There are no cost overruns. For the construction of facilities, the Bureau of Prisons uses "firm, fixed price" contracts. Under this method, the contractor builds the facility for the amount bid and accepted by the Government.

The BOP includes agreed-upon construction schedules as part of the contract. If the agreed upon schedule is not met, appropriate penalties may be assessed.

We also want to mention the Miller Act requires performance and payment bonds for any construction contract exceeding \$25,000. Performance bonds are 100 per cent of the contract price and are necessary to protect the Government's interest.

Mr. MCCOLLUM. The last question altogether is: I assume that if we were to eliminate Davis-Bacon, it would reduce prison construction costs, just like it would Federal prison construction costs, just like it would if we eliminated it for highway construction or any other Federal project. We, obviously, have Davis-Bacon requirements right now; is that not true?

Ms. HAWK. Well, it would somewhat. We were questioned by OMB and the folks in the procurement office as to just what the impact was, and we can get that information to you. But I remember that the impact was not quite as dramatic as I expected it to be in terms of prison construction, but we can get that information to you also, sir, and do the comparison for you.

[The information follows:]

DATA CONCERNING ELIMINATION OF THE DAVIS-BACON ACT

We would anticipate that the elimination of the Davis Bacon Act would result in marginal, if any, cost savings for the Bureau of Prisons. I should also note that in a letter to the Senate Labor and Human Resources Committee on March 28, 1995, the Secretary of Labor indicated that he would recommend that the President veto a repeal of the Davis-Bacon Act. The Administration opposes repeal of the Davis-Bacon Act or piecemeal repeal of any of its current basic coverage which affords essential protections to workers employed on Federal construction contracts. The Administration supports streamlining Federal contracting and procurement processes and reforming the Davis-Bacon Act, while maintaining the basic protections afforded by the Act.

Mr. MCCOLLUM. Well, since I have asked some followup questions, certainly, Mr. Scott, you may ask a couple.

Mr. SCOTT. Thank you, Mr. Chairman.

Dr. Hawk, I think you indicated that adding a little bit extra doesn't cost that much more in the life cycle of the prison. It's my understanding that over a 20-year cost of a prison only about 10 percent of that is construction; is that about right? So if you added a little extra, you'd be in de minimis extra cost?

Ms. HAWK. Absolutely.

Mr. SCOTT. In Virginia we have a program called Virginia Cares that gives counseling 6 to 7 months before release and support six or seven months after release. That program has been shown to be very effective in reducing recidivism. Do you have a similar program in the Federal system?

Ms. HAWK. I'm not familiar with your program, so I'm not sure if it's going to compare exactly, but what we do have is a prerelease program in our institutions that inmates are enrolled in at sometimes close to a year from release, but definitely 6 months before they're released. We then require that almost every one of our inmates are released through a halfway house program, so that we

not only are able to assist them; but we bring in the probation office; we bring in some job skill counselors; we bring in lots of other people that they can connect to when they get back out into the community while they're with us in the prerelease program. Then also when they're in the halfway house program, it's a requirement of our contractors to link these people coming out of prison with all the services they're going to need, whether it's job skills, housing or other needs. Drug treatment is an absolute requirement for our inmates, and any of the other services that they need. And so inmates receive prerelease assistance in the latter part of their sentence with us—as it sounds like your State does—then, also, through the halfway house program as they go back into the community.

Mr. SCOTT. And has that process been evaluated to see if it actually works?

Ms. HAWK. You know, we have not done real clean research to identify that it works, but I think anyone that's been involved in it would certainly speak anecdotally that it has a profound impact. And when we look at some of the inmates who don't have many resources to go back to, rather than running them in a separate group and not getting them in the halfway house, in order to test it, we really don't feel that that's a real wise thing to do because we really feel that they would have a very difficult time adjusting to the streets without some transition opportunity through a halfway house program.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. MCCOLLUM. Mr. Buyer, Mr. Coble, do either of you have other questions you wish to inquire? Mr. Coble.

Mr. COBLE. One brief question. Mr. Chairman, I thank you for having directed attention to constructions costs.

Director Hawk, I'm not pointing an accusatory finger at you and your agency necessarily, but all of us know that the Federal Government and most Federal agencies have a net—make that “sorry,” Mr. Chairman, to use my other word—have a sorry track record when it comes to being cost-effective. When I see construction of new Federal facilities or renovation of Federal facilities, I get heartburn. I figure, is anybody watching the meter as it runs? Probably not. But, anyway, that's the bad news. Thanks for mentioning it, Mr. Chairman.

I wanted to follow up, Director, on Mr. Heineman's question concerning conjugal visits, and you said some of those pregnancies may well have occurred during the last year?

Ms. HAWK. If they're released on furlough.

Mr. COBLE. Yes.

Ms. HAWK. An inmate is eligible for furlough in the last year of their sentence.

Mr. COBLE. Did any of those pregnancies involve staffers of BOP?

Ms. HAWK. I don't believe so, sir. I do know that we had two staff members that have been convicted of having sexual relations with inmates over the course of the last few years. And whenever we become aware of such a situation, we not only deal with it internally through disciplinary processes, but we go for prosecution on these individuals. And I do know that we had at least two male staff members prosecuted for inappropriate sexual relations with in-

mates. I do not believe that any of the pregnancies were the result of those situations, but I do know that we treat very harshly any of our staff members that gets involved inappropriately with an inmate, whether it be a female staff member with a male inmate, or whatever it might be, but we go after prosecution on these individuals.

Mr. COBLE. I'd like to know with certainty whether or not any staffers were involved when you send me——

Ms. HAWK. Sure.

Mr. COBLE [continuing].—The base closing information on the utilization of the base closures.

Ms. HAWK. Sure.

Mr. COBLE. Thank you.

[The information follows:]

CLARIFICATION AS TO WHETHER ANY INMATE PREGNANCIES HAVE BEEN THE RESULT OF THE INMATE'S RELATIONS WITH A STAFF MEMBER

Due to the lack of proof from medical tests, in no instance can the Bureau of Prisons be absolutely certain that any inmate became pregnant as a result of sexual relations with a staff member. However, the Bureau is relatively certain this occurred in one instance in 1993 in which the staff member resigned as a result of an inmate's allegations of sexual relations and subsequent pregnancy. The inmate terminated the pregnancy through an abortion.

Ms. HAWK. May I comment, please, on your comment about the Federal Government in general doing a good job?

Mr. COBLE. Yes.

Ms. HAWK. I have tremendous respect for the staff in the Bureau of Prisons who have handled our construction contracts and all of our bid processes, and we are very careful to follow the letter of the law. Since we have received so much money from Congress over the last several years, we have been scrutinized extremely heavily by GAO, by the Office of Inspector General, by anybody who is interested in those large amounts of money, ensuring that we spend every penny exactly as it should be. And I will hold our program up to any program in the Government or in the private sector for scrutiny and review by anyone because we are very much aware of how difficult it is to get taxpayers' dollars and what a tremendous responsibility we have to spend that in a prudent and wise manner. And I just wanted to say that our group in that regard are exemplary and not "sorry," sir.

Mr. COBLE. If there is a Federal agency that is exemplary when it comes to cost-effectiveness, Mr. Chairman, I'll be glad to buy some gold stars and present those gold stars to the appropriate agency.

Thank you, Director. Thank you, Chairman.

Mr. MCCOLLUM. You're welcome, Mr. Coble.

Mr. Buyer, you did want to follow up?

Mr. BUYER. Mr. Chairman, real briefly, just in response to this, and then I have a 10-second question to ask you.

I'm not going to quibble with you. When America says to us that they don't like particular trends, we kind of refer to them as megatrends in our society, and where we seek to change a trendline and bring society back into a scope for which the American people will agree, within a megatrend there are macrosystems, and of those macrosystems, then it moves down to microsystems.

So when you say to us that you're doing the very best within and following the letter of the law, I look at that and view that as within the microsystems, but our responsibility right now is to also look at it from the macro point of view as: is that law the correct law? Is that regulation correct? Are there better ways to do it or change those laws? So in no way should you take our challenges or criticisms and reflect them whether you are or are not doing a good or an adequate job.

Ms. HAWK. I absolutely understand what you're saying and would agree.

Mr. BUYER. So when we talk about not only do families restructure and businesses restructure, government should restructure also. So that's—

Ms. HAWK. Absolutely.

Mr. BUYER [continuing]. Where we are within that.

Ms. HAWK. And we fully embrace the need to continually look for cost efficiencies in every way we possibly can. I just felt the need to—

Mr. BUYER. OK.

Ms. HAWK [continuing]. Comment about our staff on that, I think, because they do a nice job.

Mr. BUYER. Actually, in that effort you can never claim victory.

Ms. HAWK. OK.

Mr. BUYER. My question, though, is, recently, you testified that in Hawaii for this construction you're going to be doing it a little bit differently?

Ms. HAWK. Yes.

Mr. BUYER. When was that decision made to do that on a one-contractor basis?

Ms. HAWK. I'd say within the last year.

Mr. BUYER. Within the last year?

Ms. HAWK. I couldn't say exactly. I can't tell you exactly when it was made, but I know it was made sometime within the last year. We've been reviewing that as a possibility, and we've made adjustments to our construction process over the years, where we've brought in construction managers and made other adjustments that were suggested over time. I'm not exactly sure when that piece was determined, but if you're interested, I could provide more information—

Mr. BUYER. If it's within the last year, I was curious.

Ms. HAWK. OK.

[The information follows:]

#### DECISION CONCERNING FUTURE METROPOLITAN DETENTION CENTER IN HONOLULU, HI

No final decision has been made at this time to undertake a design/build/operate contract for the subject facility, rather this option is under serious consideration. The potential of using this approach was first discussed within the Bureau of Prisons in the spring of 1995. The President's Fiscal Year 1996 Budget stated the Administration's intent to privatize all future pre-trial detention facilities. Construction funds had already been appropriated for all of the planned facilities, with the exception of Hawaii. Consequently, the Hawaii facility was and is the only currently planned detention facility which would permit this approach. On June 3, 1995, the Bureau of Prisons issued a pre-solicitation notice in the Commerce Business Daily in order to determine private sector interest in a design/build/operate contract. Response to this notice has been positive.

Mr. BUYER. Thank you, Mr. Chairman.

Mr. MCCOLLUM. All right, fair enough.

Mr. Heineman, do you have any followup questions?

Mr. HEINEMAN. No, Mr. Chairman.

Mr. MCCOLLUM. Mr. Chabot.

Mr. CHABOT. No.

Mr. MCCOLLUM. Mr. Barr.

Mr. BARR. Very briefly, Mr. Chairman, thank you.

In your written testimony, Dr. Hawk, you talk about uniform implementation of Federal death sentences. Will the administration be submitting specific proposed legislation? I know you have a suggestion in your material. Will you be submitting a proposed amendment?

Ms. HAWK. Absolutely, sir. I believe that's an error. I believe it was just simply an error made in the 1994 crime bill when they went back to some old language, even though the new language was that we would do it in the Federal Bureau of Prisons and it would be by lethal injection, and the rules had already been published and completed in that regard. I think it was simply an oversight in the 1994 crime bill that went back to the old language that said it would be done by the States, by the method used in the State in which the individual was convicted. So we, I believe, maybe already have come forward with adjusted legislation, or will very soon, to address that, because right now it's a very confusing issue.

Mr. BARR. OK. With regard to Federal inmates currently under Federal death sentences, what is the status of the appeals and what is the time frame within which it's anticipated that the first execution will be carried out?

Ms. HAWK. We have six inmates so far that have been sentenced to death at the Federal level. I did set a date for execution of the end of this past March for one inmate. That enabled him, then, to start his final round or his next round of appeals, and those will take at least a year for him to exhaust. So we believe the earliest time that anyone would be executed—unless any of the other five inmates choose not to use up their appeals, if they choose not to appeal, it could occur at any time—but we believe the earliest one would be at least a year from now.

Mr. BARR. OK. And just to follow on with a comment, I understand through our previous discussion some of your explanation about the health care costs. I still am somewhat concerned about both the magnitude of them and what we are providing folks. Frankly, it doesn't strike me as a wise use of taxpayer money to provide dental services because they may not be able to chew food, or whatnot. They can eat soup or something. But I think there's a gray area there, and I think we are spending perhaps too much money.

If you do have the opportunity or see some studies or some statistics somewhere that gives us some benchmark to compare these costs to State or local costs, even within the framework that there are going to be a lot of differences perhaps, I'd very much like to see that.

Ms. HAWK. OK, absolutely.

[The information follows:]

# STUDIES THAT HAVE COMPARED INMATE HEALTH CARE COSTS ACROSS DIFFERENT CORRECTIONAL SYSTEMS

The following three studies [see appendix] variously relate to this issue and are provided for the record. "Privatize Federal Prison Hospitals: A Feasibility Study" [appendix 1] is a 1990 study assessing the potential for the Bureau of Prisons' to privatize any of its medical referral centers. "The Cost of Correctional Health Care" [appendix 2] relates the results of a 1990 survey of health services spending in correctional systems. "Managing Prison Health Care and Costs"<sup>1</sup> is a review of current approaches to managing health care and health care spending for inmates.

Many issues must be taken into account when comparing health care costs and spending between and across different correctional systems, either government provided or privately provided. A significant issue is the services package provided to inmates. Different levels of services translate to different costs. The most common examples of differences in this area are the nature of dental services provided, the level (if any) of mental health services, whether hospitalization is included, and if coverage includes catastrophic medical expenses and at what amount.

Health services staffing and inmate access to providers is another significant matter that should be addressed in any comparison. In this area, it is important to know the total staffing complement and duty hours of health care providers. Correctional systems and individual institutions will differ with regard to physicians being on duty or on call. They will also differ as to whether inmate's initial contact is with a physicians assistant, a nurse practitioner, a licensed practical nurse, or a registered nurse. Differences will also occur in the area of "after-hours" or "24-hour" coverage.

Mr. MCCOLLUM. Thank you, Mr. Barr.

And thank you, Dr. Hawk, for spending 2 hours with us this morning, but it was a good 2 hours.

Ms. HAWK. OK.

Mr. MCCOLLUM. We look forward to getting the comments you're going to submit for the record. We also look forward to working with you on other hearings.

Ms. HAWK. Thank you, sir.

Mr. MCCOLLUM. Thank you.

Our next panel, our second panel of guests, I'd like to introduce, and when I do, if they could come up at the witness stand—there are five—and be seated in the chairs. I think we have to add one seat to that. If some staff member would do so, I would appreciate it.

Our first witness will be Norman Rabkin, Director of Administration of Justice Issues in the General Accounting Office's Government Division. Mr. Rabkin is responsible for reviews of the Department of Justice, including its State and local assistance programs and the FBI, the investigative agencies of the Department of the Treasury, and the judicial branch of the Federal Government. Mr. Rabkin has held several positions at GAO prior to being appointed Director of Administration of Justice Issues in October 1994.

Our next witness is Walter Brys, cofounder of North Village Corp., a correctional facility development company headquartered in Kingwood, TX. North Village and its principals have been involved in the development of approximately 10,400 criminal justice beds, the majority of which have been authorized under privatization programs initiated by various government entities.

Our third witness is Dr. Charles Thomas, professor of criminology at the University of Florida, where he is also director of the Private Corrections Project. Dr. Thomas has published numerous

<sup>1</sup> The publication referred to above, "Managing Prison Health Care and Costs," is in the subcommittee files.



research journal and law review articles on the correctional privatization movement. He's also testified before and worked with legislative groups across the Nation and has assisted them in the drafting of legislation on the issue.

If I get this correctly, I think we have—yes, our fourth witness is Dr. Shapiro. Dr. Shapiro is a physician and president and chief executive officer of Prison Health Services of New Castle, DE. He has over 23 years of experience in health care management, including 5 years as commissioner of public health for the city of Philadelphia. Dr. Shapiro has also served as senior staff member to the U.S. Senate Committee on Health and Scientific Research and as deputy commissioner for the Massachusetts Department of Public Health. Prior to joining Prison Health Services, Dr. Shapiro was in private practice.

And our fifth witness is Dr. Douglas Lipton, senior research fellow of the National Development and Research Institute, which was established in 1967 to conduct drug abuse-related research. The National Development and Research Institute's mission is to research, train, provide outreach, prevention, demonstration projects and technical assistance, publish findings, and engage in other activities that focus on societal and other personal difficulties associated with chemical abuse, AIDS, criminal justice, and related issues. Dr. Lipton has published numerous articles concerning drug abuse treatment of prisoners. He has also served the State of New York in several capacities, including director of research and evaluation for the New York State Division of Substance Abuse, and deputy director of the New York State Office of Crime Control Planning, and assistant director of the New York State Crime Control Council. Dr. Lipton holds a Ph.D. in sociology and criminology from Vanderbilt University.

I might add that Dr. Thomas received his Ph.D. from the University of Kentucky in 1971, and since he is a Gator and I am, too, I'll forgive him for that. [Laughter.]

And I would like to start our second panel by going to Mr. Rabkin, and as we go through, if you can summarize your testimony, gentlemen, it would be helpful. We do have it for the record. As you've noticed, we've already referred to the written statement of one of the participants on this panel. We picked on one person here, and I hope you'll forgive me for that today. But, if we can, we'll go across. I know I introduced you in a certain order, but it's easier if we do this in the order in which you're seated, if Mr. Brys can forgive me for that.

Mr. Rabkin.

**STATEMENT OF NORMAN J. RABKIN, DIRECTOR, ADMINISTRATION OF JUSTICE ISSUES, GENERAL GOVERNMENT DIVISION, GENERAL ACCOUNTING OFFICE**

Mr. RABKIN. Thank you, Mr. Chairman.

I'm pleased to be here today to discuss reports GAO has issued over the past several years on the Federal Bureau of Prisons. My prepared statement, as you mentioned, reviews our principal reports on prison crowding, options for expanding the Bureau's capacity, privatization, and health care, and I'll use this time to give you a brief summary.

In the area of prison crowding, we reported in 1989 that the Federal prison population was growing faster than the Bureau had estimated. Therefore, the expansion plans it had were understated. We concluded that there were opportunities for the Bureau to make greater use of alternative sanctions for nonviolent offenders. In a 1991 report we noted that on average fewer than half of the inmates scheduled for release and eligible for consideration were actually placed in halfway houses. We recommended that the Bureau clarify its placement policy and use established procedures to better identify suitable candidates for placement.

In 1993, we reported that the Federal bootcamp program was too small to help reduce overall costs and prison crowding and it was too early to assess the program's impact on recidivism. Although most of the State officials we surveyed believed their programs reduced short-term costs and crowding, we concluded that there was no clear indication that State-run bootcamps had measurably reduced recidivism.

On the issue of how the Bureau was expanding its capacity, we focused in 1991 and 1992 on the Bureau's single-bunking standard for estimating the capacity of its prisons. We helped convince the Bureau to convert to a double-bunking standard. This, and the Bureau's decision to reduce its planned space per inmate, enabled it to avoid an estimated \$1 billion in construction costs.

During the 1980's, prison overcrowding, court orders to reduce it, and budgetary considerations led several States to place inmates in privately-run prisons. At the Federal level the use of privatization was limited to incarceration of specialized groups such as illegal aliens. We reported in 1991 that research on the benefits of privatization—that is, reducing costs while providing comparable services—was inconclusive. We suggested that more research would be useful to determine what role, if any, privatization should play in the Bureau's overall expansion plans. As you know, the Bureau's fiscal 1996 budget request proposes privatizing the management and operation of several prisons.

Over the years we have reported on various aspects of the Bureau's attempts to meet the health care challenges of its changing prison population. Our work covered the quality and quantity of care provided to all inmates, including those with mental health and drug abuse problems and other special needs. For example, in 1991, we reported that about two-thirds of mentally ill inmates identified by court or Bureau officials were being enrolled in treatment programs. However, not all mentally ill inmates were being screened, diagnosed, and treated. At that time BOP was making several changes to improve its identification and treatment of mentally ill inmates.

According to Justice Department data, drug offenses accounted for half of all offenders sentenced to Federal prisons in fiscal years 1989 through 1993, and many of these offenders had substance abuse problems. We reported in 1991 that drug treatment was reaching less than half of the inmates with serious substance abuse problems. At that time the Bureau was planning to expand the investment in its treatment programs from an estimated \$7 million in 1990 to more than \$21 million in 1992. And, according to a Bu-

reau official, the annual investment has remained at about \$21 million since then.

Last year we reported that inmates with special needs were not receiving adequate health care. This situation was occurring primarily because there were insufficient numbers of physician and nursing staff to perform the required clinical and other related tasks. In addition, two of the three medical referral centers that we reviewed had failed to correct identified quality assurance problems. We made several recommendations to the Bureau to improve inmates' access to quality care, and in February of this year the Bureau informed Congress of numerous changes and pilot studies that it had initiated in response to our recommendations.

The Bureau will most likely continue to be confronting the challenges of increases in the number of inmates, inmates serving longer sentences, more demands on its health care system, and greater overall correctional costs. The Bureau recently issued a report on its goals for 1995 and beyond. Its mission statement, which sets the tone for how it intends to carry out its statutory responsibilities, focuses on confining offenders in appropriate facilities and environments. Our work suggests that the principal barrier the Bureau will probably face in accomplishing that mission is being able to afford to provide that level of service. We believe that the Bureau, the Congress, and other important stakeholders in this country's criminal justice system will need to focus their attention on what an appropriate level of service is and how it can be provided in an era of reduced Federal budgets and work forces. To assist the Congress in its oversight, GAO will continue to monitor such issues as privatization, alternatives to incarceration, expanded capacity, inmate health care, and other emerging issues.

Mr. Chairman, this completes my statement and I'll be glad to answer your questions and those of the rest of the committee.

[The prepared statement of Mr. Rabkin follows:]

PREPARED STATEMENT OF NORMAN J. RABKIN, DIRECTOR, ADMINISTRATION OF  
JUSTICE ISSUES, GENERAL GOVERNMENT DIVISION, GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you today to discuss our recent reports on the Federal Bureau of Prisons (BOP). Responding to congressional concerns and challenges to BOP and correctional systems across the country, our federal corrections work during the past 8 years has focused on four areas: prison crowding, options for expanding BOP's capacity, privatization, and health care (including drug treatment). In my testimony today, I will briefly describe the challenges and issues we believe confront BOP, recap our key findings and recommendations on these matters, and highlight concerns for the future. A list of our related products is attached.

CHALLENGES TO THE FEDERAL PRISON SYSTEM

Over the past decade, new criminal justice policies and demographic changes in the prison population have affected corrections systems across the nation. As a consequence of these policy and population changes, BOP as well as state and local correctional systems have confronted new challenges. Four challenges, in particular, deserve special consideration: the increasing number of prison inmates, inmates serving longer sentences, demands on BOP's health care system from a more diverse prisoner population, and increased financial burdens on government systems to pay for correctional costs. Let me briefly

address these changes and challenges in relation to federal corrections.

During the 1980s, Congress enacted several statutes that dramatically affected the federal prison population. These statutes included the Comprehensive Crime Control Act of 1984 and the Anti-Drug Abuse Acts of 1986 and 1988. Provisions in these acts expanded the types of crimes subject to federal prosecution and established mandatory minimum sentences for certain crimes, particularly drug offenses and violent crimes. The 1984 Crime Control Act created the U.S. Sentencing Commission, which was charged with developing the federal sentencing guidelines that took effect on November 1, 1987.

Perhaps the most visible consequence of these federal initiatives has been the increase in the federal prison population. Between 1986 and May 1995, the federal prison population more than doubled to about 42,000 to 88,875. In addition, nearly 10,000 individuals were in federal custody in halfway houses, home confinement, or contract jails. BOP projects the prison population will be more than 100,000 by the end of fiscal year 1996.

New federal policies affect the time served by federal inmates. Those sentenced under the guidelines are not eligible for parole and must serve their entire sentences less a maximum "good time"

reduction of 54 days per year. The effect of these provisions combined with more restrictive eligibility standards for nonprison sentences, has lengthened the sentences that federal inmates serve.

The inmate population, itself, has changed, presenting new challenges to BOP. Longer sentences combined with the requirement that inmates now serve at least 85 percent of their sentences are resulting in a growing BOP population of older inmates. For example, from 1990 to 1993, the percentage of federal prison inmates over age 55 grew 43 percent, from 3,222 to 4,596. Though still less than 10 percent of the total BOP inmate population, the proportion of women in BOP's total population continues to grow. The number of HIV positive inmates has grown to about 2 percent of the total population. The spread of drug-resistant strains of tuberculosis presents an emerging threat in crowded institutions. Further, many federal offenders have substance abuse problems, as drug offenses have accounted for about half of all offenders sentenced to prison in federal courts for fiscal years 1989 to 1993, according to Department of Justice data.

This changed population has created challenges for the system, particularly in the area of health care. Older inmates generally have more frequent and more severe medical problems than younger inmates. As HIV positive inmates develop AIDS-related

complications, the cost of their medical care rises dramatically. Inmate demand for treatment services has increased, leading to rising costs.

The impact of changing policies and inmate populations have serious budgetary implications for BOP and the federal government as a whole. Federal costs for incarceration and supervision continue to rise as the federal government builds more prisons and hires more staff to meet the demands of the growing inmate population. From fiscal years 1990 through fiscal year 1995, total BOP positions rose from 17,896 to 29,306. During the same period, total appropriations rose from \$2.5 billion to \$2.6 billion. However, the fiscal year 1990 appropriation included \$1.4 billion for construction of new facilities. The real growth in BOP's budget has been the cost of operating existing facilities. Between fiscal years 1990 and 1995, BOP's appropriation for salaries and expenses grew from \$1.1 billion to \$2.4 billion. In its Goals for 1995 and Beyond, BOP reported that it plans to add 43 correctional facilities and increase capacity by 35,873 beds.

#### GAO'S FINDINGS AND RECOMMENDATIONS

Our past work provides a good perspective for understanding how BOP can respond to these challenges. During the past 8 years, we have addressed the issues of prison crowding, options for

expanding BOP's capacity, privatization, and health care (including drug treatment). I will briefly review some of our principal reports in these areas, highlighting our findings and recommendations and, where appropriate, BOP's responses.

### Prison Crowding

In 1989, we reported that during the 1980s the federal prison inmate population doubled from 24,162, which was less than 1 percent over capacity, to 48,017, about 56 percent over capacity. At that time, BOP projected its inmate population to grow to about 83,500 by 1995. It also had plans to more than double its capacity by 1995, at a cost of about \$1.8 billion in new construction, expansion of existing facilities, conversion of surplus military or civilian facilities, and leasing.

We indicated that if the prison population grew at a greater rate, which later BOP estimates indicated, the crowding would not be eliminated and extensive expansion would still be needed after 1995. We then embarked on a series of assignments to examine BOP's needs and suggest other options through which BOP could meet them.

We believe that there are opportunities for BOP to make greater use of alternatives to traditional prisons for nonviolent



offenders. Within the federal system, three alternatives are available:<sup>1</sup>

- probation with a confinement condition such as to a halfway house, the offender's home (with or without electronic monitoring), or to a jail for nights or weekends;
- a "split sentence," which is a short prison sentence followed by supervision in the community with a confinement condition such as to a halfway house or the offender's home (with or without electronic monitoring); and
- boot camps or "shock" incarceration.<sup>2</sup>

In a 1991 report, we noted that BOP was not making full use of available halfway house beds. In practice, fewer than half of the inmates scheduled for release and eligible for consideration were placed in halfway houses. We recommended that BOP clarify its policy, use proven procedures to better identify suitable candidates for placement, ensure that wardens start the placement process in a timely manner, and define when placement could be refused. BOP has generally implemented our recommendations for

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<sup>1</sup>The types of sanctions available are governed both by statute and the sentencing guidelines developed and published by the U.S. Sentencing Commission.

<sup>2</sup>Boot camps subject inmates to military style basic training techniques in a corrections setting. They generally target young nonviolent offenders who have not yet committed a major felony.

enhancing the use of available halfway house resources. BOP's objective is to place in halfway houses 80 percent of prisoners being released from minimum security prisons, 70 percent from low security, and 65 percent from medium security.

In 1993 we reported that the federal boot camp program was too small to help reduce overall costs and prison crowding, and it was too early to assess the program's impact on recidivism. Although most of the state officials we surveyed believed the programs were successful in reducing short-term costs and crowding, we concluded that there was no clear indication that boot camps had measurably reduced recidivism.

#### Expanded Capacity

We addressed the issue of whether BOP was expanding its capacity at the least cost to taxpayers from two perspectives. First, we focused on BOP's policies and standards that influenced its rated capacity--the maximum number of inmates for which its facilities were designed (not including capacity set aside for medical and disciplinary segregation). Second, we looked at BOP's identification and evaluation of surplus military property for prison use.

We reported in 1991 that states built prisons at a lower cost per bed than BOP, primarily because federal design standards provided

for one inmate to a cell (single-bunking), 55 percent more space per inmate, and more dedicated space for inmate programs. We also reported that despite operating at 60 percent over its rated capacity, BOP had not experienced unmanageable problems in double-bunking. We made several recommendations to get BOP to incorporate double-bunking into its design standards as much as possible.

BOP revised its design standards for determining prison capacity from single-person cells to two-person cells, thus significantly increasing capacity at both existing and planned facilities.<sup>3</sup> BOP also revised its policy to change the space allocated per cell from 90 square feet to 75 square feet. In its fiscal year 1995 budget submission, BOP estimated that implementing the double-bunking changes would add 25,000 beds to current capacity through fiscal year 1997, saving an estimated \$1 billion in additional construction costs.

In 1990, we recommended a more thorough review of excess military property for use as federal prisons. BOP uses both active and closed military installations as correctional facility sites. By 1993, BOP

-- had 9 minimum security facilities on active military bases,

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<sup>3</sup>BOP's policy is to use two-person cells in 100 percent of minimum and low security facilities, 50 percent in medium security, and 25 percent in high security.

-- had 14 facilities in operation and 8 under design or construction on 16 deactivated bases or former military property,

-- had acquired 2 additional military properties, and

-- was evaluating and pursuing 15 other military properties as potential sites.

#### Prison Privatization

During the 1980s, prison overcrowding, court orders to reduce it, and budgetary considerations led several states to place inmates in privately managed prisons. At the federal level, use of privatization had been limited to specialized groups (e.g., illegal aliens) and unsentenced offenders. In 1988, the President's Commission on Privatization recommended that BOP contract for private sector operation of a medium or maximum security prison as a basis for comparison with a similar facility operated by BOP. BOP submitted a proposal to use private contractors to build and operate a minimum security facility. The Senate Committee on Appropriations denied that request. The Committee was concerned that the proposal signaled a first step in privatizing the federal prison system, which it opposed on public policy grounds.

In response to a request of the House Small Business Subcommittee on Regulations, Business Opportunity, and Energy, we reviewed BOP's documents and reported in 1991 that research on the benefits of privatization--i.e., reducing costs and providing<sup>d</sup> services--was inconclusive. We suggested that more research and testing would be useful to determine what role, if any, privatization would play in BOP's overall expansion plans. We recommended that Congress grant BOP the explicit authority to conduct and evaluate a pilot test of privatization in conjunction with the National Institute of Justice. To date, such authority has not been granted to BOP.

BOP currently contracts with private firms for halfway houses (which BOP now calls Community Correction Centers), detention of juveniles, electronic monitoring, and some jail and detention facilities. About 10 percent of BOP's total inmate population is housed in contract facilities. BOP's fiscal year 1996 budget request proposes privatizing the management and operations of several prisons, including the pretrial Metropolitan Detention Center in Brooklyn, NY, and minimum and low security federal prisons in Forrest City, AR; Taft, CA; and Yazoo City, MS.

Inmate Health Care

Over the years, we have reported on various aspects of BOP's attempts to meet the health care challenge of its changing population. Our work covered the quality and quantity of care provided to all inmates, including those with mental health and drug abuse problems as well as other special needs.

In 1991, we reported that about two-thirds of mentally ill inmates were being enrolled in treatment programs but not all were being screened, diagnosed, and treated. A BOP advisory group recommended that additional resources, improved staff training, more detailed information on inmate needs, and an overall quality assurance program were needed to cope with these problems. At the time of our report, BOP had implemented some of the group's recommendations and was considering others. We concluded, however, that given the challenges of prison overcrowding, budgetary restraints, and the difficulties in hiring sufficient staff, it remained to be seen how thorough and effective BOP would be in implementing all its plans.

According to Department of Justice data, drug offenses have accounted for about half of all offenders sentenced to prison in federal courts for fiscal years 1989 to 1993. Many of these offenders have substance abuse problems. We reported in 1991 that drug treatment was reaching only a small fraction of inmates

with serious substance abuse problems. As of April 1, 1991, only 364 inmates were receiving treatment in the intensive residential programs,<sup>4</sup> and less than half of the treatment slots were filled. For inmates with less serious substance abuse problems, needed services were not available in all prisons. At that time, BOP was planning to expand the investment in its treatment program from an estimated \$7.2 million in 1990 to \$21.8 million in 1992.

In 1992 and 1993, in response to congressional concern regarding allegations of patient neglect, unacceptable medical practices, and incompetent physicians in BOP, we reviewed medical services at three of BOP's seven medical referral centers. We found that inmates with special needs, including women, psychiatric patients, and patients with chronic diseases, were not receiving all of the health care they needed. This situation was occurring because there were insufficient numbers of physician and nursing staff to perform the required clinical and other related tasks. In addition, two of the three centers failed to correct identified quality assurance problems.

Although BOP strongly disagreed with our conclusions, it agreed with our specific findings. We made several recommendations to BOP to improve inmates' access to quality care. In February

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<sup>4</sup>Prison residential treatment programs provide living quarters and treatment facilities for participating inmates separate from the general inmate population.

BOP informed Congress of numerous changes and pilot studies that it had initiated in response to our recommendations. For example, BOP was implementing a pilot study to determine whether the cost to provide medical services could be reduced through the use of Preferred Provider Organizations and sharing agreements with other federal agencies, such as Department of Veterans Affairs hospitals. In addition, BOP is seeking legislative authority to require their private sector health care providers to bill at Medicare rates.

#### CONCERNS FOR THE FUTURE

As we enter the 21st century, BOP will probably continue to confront the challenges of increasing numbers of inmates, inmates serving longer sentences, demands on its health care system, and increasing correctional costs. BOP issued a report on its goals for 1995 and beyond. BOP's mission statement, which sets the tone for how it intends to carry out its statutory responsibilities, focuses on confining offenders in appropriate facilities and environments. Our work suggests that the principal barrier BOP will probably face in accomplishing that objective is being able to afford to provide that level of service. We believe that BOP, Congress, and the other important stakeholders in this country's criminal justice system will need to focus their attention on what an appropriate level of service



is and how it can be provided in an era of reduced federal budgets and workforces.

To assist Congress in its oversight, we will continue to monitor such issues as inmate health care, privatization, alternatives to incarceration, expanded capacity, as well as other issues as they emerge.

Mr. Chairman, this completes my statement. I would be pleased to answer any questions.

Mr. McCOLLUM. I have reconsidered the order in which to go, Dr. Lipton, only because my staff tells me that everybody was introduced for a particular reason in the order, in order to consolidate everybody in some kind of sequence of subject matter. So I'm going to go to Mr. Brys, since I introduced you second; you were listed here for a reason that way—

Mr. BRYs. Thank you.

Mr. McCOLLUM [continuing]. And we'll come back and do it in the order I introduced, but we'll be skipping around at the table for that reason, because we didn't seat you that way.

Mr. Brys, please proceed.

#### **STATEMENT OF WALTER A. BRYs, PRINCIPAL, NORTH VILLAGE CORP.**

Mr. BRYs. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, thank you for affording North Village Corp. the opportunity to share with you some of our observations and insights on the subject before you today.

North Village Corp. is a correctional facility development company, and during recent past years it has been involved in the design and development of approximately 10,000 criminal justice beds. The majority of the projects have been developed in urban locations.

Since the 1980's, the public policy debate on pros and cons of contracting government services has grown and grown. In that regard, we believe the Federal Government and the Bureau of Prisons could reap substantial cost savings by adopting a more coherent approach to utilizing the services offered by the private sector.

In this context, I would like to dedicate the thrust of my testimony today on Bureau of Prisons procurement as pertains to turnkey facility construction. I assure the subcommittee and the Bureau that my comments on procurement are intended to be constructive.

To prep myself for today's hearing, I reread Director Hawk's testimony before your Appropriations Subcommittee counterparts earlier this year, and according to that testimony, the BOP will be activating somewhat 9,000-plus beds this coming year. They'll be moving to greater use of double-bunking, campus-style configurations of housing, and a more aggressive privatization effort toward facility management, and I applaud all of those efforts.

I am most concerned that in this last initiative privatization is too narrow and is missing an opportunity to save millions by simply refining and consolidating its procurement procedures. Streamlining should include simplifying accounting and payment procedures, paperwork reduction measures, and consideration of repeal of Davis-Bacon requirements on cost of construction.

Jails, detention centers, and prisons are unique in specialized forms of development which should be handled by firms that have the proven ability to intelligently design and construct these types of facilities. Turnkey contracting with such firms will often alleviate or eliminate the need for governmental micromanagement of projects, which historically has been a driving factor inflating the project cost to the taxpayer.

Mr. Chairman, in Houston, TX, the Federal Bureau is currently moving toward building a 250,000-square-foot, 677-bed highrise facility under its metropolitan detention program in an urban setting for about—for approximately \$50 to \$55 million. As a businessman and a taxpayer, this is troubling because it comes at a time when my company in Dallas, TX, in the Dallas, TX, area, shall soon have a 240,000-square-foot State jail built in an urban setting at a cost of \$38.8 million. The facility will house 1,323 more inmates than the proposed Houston facility the Federal Bureau of Prisons is talking about.

The BOP 677-bed Houston detention center project has had a number of difficulties thus far, and a most recent effort included their announcement that in mid-March that it had selected a new site in downtown Houston. This was the second attempt because their first attempt at siting the facility happened to be across the street from a Catholic girls' school, which did not—was not well received by the community.

Negotiations are currently underway, apparently, to purchase the second site, and I am sure were welcomed by the landowner and slanted in his favor. Mr. Chairman, this is an example of the kind of a la carte procurement that the BOP utilizes. While the BOP would, no doubt, scoff at this example as an apples-and-oranges comparison, we do not see that to be the case. Their Houston facility will have been in the works for about 6 to 7 years now before it comes online. Our total turnkey schedule for the 2,000-bed Dallas State jail facility is 15 months. That's all aspects of the project, start to finish, and that schedule will be met. We'll be opening that facility in September of this year.

In recent months North Village Corp. has been evaluating and comparing items that most affect the wide differences in typical project costs for a North Village response to an RFP, to an advertised RFP, for a turnkey prison versus BOP experience for similar requirements. The major items affecting BOP's substantially higher totals were, No. 1, the facilities were sized as much as twice that of recognized published standards. No. 2, schedule time was typically represented in terms of years rather than months, and there was no indication of a guaranteed schedule for the project. No. 3, the project costs were subdivided into categories or minor categories, each with contingencies, and there were no apparent guarantees on each project line for cost overruns.

Mr. Chairman, there is, indeed, a huge quantity of Federal funds that could go a lot further than they do today, if the BOP would embrace a construction strategy that asks bidders to include in their turnkey proposals land acquisition, environmental impact assessments, design and engineering services, public and community support documentation, construction, and full furnishings, all for a guaranteed price and a guaranteed schedule. This would effectively transfer cost, schedule, and contracting risk away from the BOP and require the bidder to manage these issues.

Again, I thank the subcommittee for allowing me to testify today. North Village believes that if more Federal projects, even pilot projects, were opened up to turnkey competitive bidding, the taxpayers would be the beneficiary of the process.

I would be pleased to answer any questions that you may have.  
Thank you.

[The prepared statement of Mr. Brys follows:]

PREPARED STATEMENT OF WALTER A. BRYN, PRINCIPAL, NORTH VILLAGE CORP.

Mr. Chairman, Members of the Subcommittee, thank you for affording North Village Corporation the opportunity to share with you some of our observations and insights on the subject before you today. North Village Corporation is a correctional facility development company; my partner and co-founder, Mr. Brett Rule, regrets that he was unable to join me today. Together, during five short years since the company's inception, we have been involved in the design and development of approximately 10,400 criminal justice beds. With the exception of two mid-sized boot camp facilities, all of North Village's major projects have been developed in urban locations.

Since the 1980's, the public policy debate on the pros and cons of contracting out government services has grown and grown. That has especially been the case among State, County and Municipal governments in the area of jail and prison management. As has been the result in Texas, which has been quite progressive in this regard, we believe that the Federal government and the Bureau of Prisons could reap similar, substantial cost savings if BOP adopted a more coherent approach to utilizing what the private sector can provide.

In this context, I would like to dedicate the thrust of my testimony today on BOP procurement as it pertains to facility construction. I assure the

Subcommittee, and the Bureau, that my comments on procurement and construction are intended to be constructive.

To prep myself for today's hearing, I re-read Director Kathleen Hawk's testimony before your Appropriations Subcommittee counterparts earlier this year. According to the BOP, their budget request will allow the Bureau to activate 9,197 new prison beds. On a number of BOP policy initiatives, such as greater use of double-bunking when acceptable and campus style configurations for new facility construction, I believe that the Bureau is indeed moving in the right direction.

However, I am concerned that the BOP's new embrace of "privatization" is focused entirely too much on facility management in an effort to cut federal FTE's. All too often when privatization is discussed in the context of the penal debate, it is the management of prisons or jails that first comes to mind given the number of private sector companies that have sprung up that do just that. However, we believe that the federal government could save millions upon millions if the BOP simply refined and consolidated it's procurement procedures for facility *construction* alone. Again Mr. Chairman, North Village does not manage penal facilities, we build them.

As part of Director Hawk's FY'96 funding request, she indicated and I quote, "in addition to the privatization initiative, we will also reduce our administrative support staff by an additional 25 percent over four years." She also indicated that BOP will accomplish this by consolidating and reducing staff in personnel, procurement, budgeting and accounting. Mr. Chairman, this is a very troubling statement to me. Not because I am against a reduction in force but because nowhere is there any mention by BOP of procurement streamlining *to augment the staff cuts*. Nowhere is there any mention of BOP accounting reform so that vendors don't have to "pad" their bids to account for less than timely payment. Nowhere is there any mention of paperwork reduction. Nowhere is there any mention of Davis-Bacon repeal when it comes to federal facility construction.

Mr. Chairman, our very young company has bid on 8 major turn-key jobs in Texas and we have won seven. Quickly, I'll tell you what I believe are the high points of why we have established that kind of solid track record. First, we provide the buyer with a quality product and to do that we (1) guarantee no project cost overruns, or we eat them; (2) we guarantee an agreed upon construction schedule or we're assessed a per day monetary penalty; and finally

(3) we pay our subcontractors on time which is just the competitive carrot they need to do their job right. I don't think the Bureau has ever even considered folding these stipulations into their process.

Jails, detention centers and prisons, Mr. Chairman, are a unique and specialized form of development which should be handled by firms that have the proven ability to intelligently design and construct these types of facilities. While government management and oversight of projects cannot be quarrelled with, it has been our experience that government *micro*-management of projects is a driving factor in inflating the cost of construction to the taxpayer. A fine line exists between the professional public servant maintaining firm control over design and construction of a facility in order to safeguard taxpayer dollars and oversight overkill that actually drives up project costs.

For instance, on the last contract North Village won and completed in Houston, Texas, for a 667-bed State Jail, the comprehensive RFP, the Request for Proposals totalled only 3 pages. As incredible as that may seem to anyone in the Federal government or at the Bureau of Prisons, by taking this tact the State's corrections officials were able to see creative proposals they never would have thought of themselves...new sites, new designs, etc.,. Granted, what was



not included in that RFP was the State Jail Standards for Texas but they are the basis for all of the proposed designs - a building code for prisons. Mr. Chairman, I brought that RFP with me and I'd like to have it included in the Record if I may (attached).

Mr. Chairman, the correctional facility development business community has evolved and expanded in recent years and there are many competent bidders in our industry. By way of example as to what we have provided our clients, let me give the Subcommittee an idea of the universe of services private sector concerns can now offer governments at any level. In addition to Guaranteed Construction Schedule and Guaranteed Price we offer:

- Site Analysis & Acquisition

We will identify a suitable site for a new facility and perform the required tests to ensure the site is free from environmental contamination.

- Community Support

Public hearings will be held to secure local support for the development.

- Project Design

The architectural team of North Village Corp. will provide a comprehensive design for the new facility tailored to the needs of the user.

- Turn-key Construction

Local construction companies and suppliers are used so that the economic benefits of the development are retained by the community. All furnishings required for complete facility operation are provided.

- Private Sector Financing and Ownership

North Village Corp. can provide construction financing for the facility under various lease-purchase structures.

Mr. Chairman, in Houston, Texas, the Federal Prisons Bureau shall build a 250,000 square foot, 677 bed high-rise facility under it's Metropolitan Detention Center program in an urban setting for approximately \$50 million. Clearly, as both a businessman and taxpayer, this is troubling because it comes at a time when the Dallas, Texas, area shall soon have a 240,000 square foot State jail *that will cost only \$38.8 million including the costs of land acquisition, design, engineering, construction, and complete furnishing of the facility.* And, the Dallas State facility, also located in an urban setting, will house 1,323 more inmates than the BOP Center.

The BOP's Houston Detention Center has had many problems. Let me share with the Subcommittee just one of the more recent problems that I

believe Members will appreciate. In mid-March the BOP announced that it had selected a new site downtown. This announcement was the BOP's second attempt to locate a suitable location, their first being to house the inmates across the street from a Catholic girls school. This new site selection, however, was publicly reported in a major daily Houston newspaper prior to any BOP discussions with the landowner to determine a fair market price for the parcel of land.

Mr. Chairman, this is the best example I can think of against the kind of "a la cart" procurement that the BOP utilizes. This type of negotiating for property by a federal government agency runs counter to common business sense and is an extremely wasteful and inefficient use of taxpayers money.

Not to belabor the point Mr. Chairman, but while the Bureau of Prisons will no doubt scoff at this example as an "apples to oranges" comparison, we do not see that to be the case. Their Houston facility will have been in the works for about 6 to 7 years before it comes on line. The total turn-key schedule for the 2000-bed Dallas State Jail is 15 months; start to finish. That schedule will be met. The Dallas jail held it's "topping out" (the tradition of placing a small tree on top of a building when the structure is complete)

festivities on May 17th.

In recent months, North Village Corp. has been evaluating and comparing items that most affect the wide differences in typical total project costs for a North Village response to an advertised Request for Proposal for a turn-key prison/jail versus BOP experience for similar requirements.

The major items affecting the BOP's substantially higher totals were:

- The BOP facilities were often sized twice that of nationally published and recognized standards.
- The BOP's total project schedule was typically represented in terms of years, rather than months. Also, the schedule was usually not guaranteed up front.
- The BOP's total project costs were subdivided into major cost categories and included a substantial total budget project contingency. The project budget was usually not guaranteed up front.

The BOP's 1996 budget request will enable it to activate seven new prisons located in Beaumont, Texas; Taft, California; Forrest City, Arkansas; Yazoo City, Mississippi; and a Metropolitan Detention Center in Brooklyn, New York. I would suggest to this Subcommittee that you merely ask two things of the BOP in order to help you draw your own conclusions on the need for facility procurement reform. One, ask if the Bureau utilized a consolidated

"soup-to-nuts" RFP for the facility bids and if so, request a copy and thumb through it. Secondly, ask the BOP how long, how many years, these new projects have been in the pipeline from conception until they come on-line.

Additionally, when juxtaposed against various State standards, such as the criteria used by the Commonwealth of Virginia for instance, professionals in the correctional facility construction field view the federal Bureau of Prisons as by far the largest provider of square footage per inmate in the correctional facility development community. This Subcommittee should be interested in this important cost escalating factor and I would respectfully suggest that your panel ask BOP to describe and justify the design standards that they use.

For instance, data we have compared on BOP prison single bunking cell dimensions averages 100 square feet per inmate whereas standards formulated and used by State prisons, not State jails but State prisons, is significantly lower. On average State prison cell space is 30 percent less than the BOP. One State, Wisconsin, allocates 54 square feet per cell for single bunked inmates. Our question is why the federal generosity? If it is the BOP's contention that federal prison criminals deserve more cell space because presumably they will be incarcerated for a longer period of time than criminals held in a State

facility, it is North Village's position Mr. Chairman that the additional square footage should be accounted for in the federal facility's recreation yard, the shop, or in other rehabilitation areas rather than in cell construction. This federal design mind-set modification alone will give federal dollars added buying power in the construction phase of a project.

Mr. Chairman, there is indeed a huge quantity of federal funds that could go a lot further than they do today if the BOP would embrace a construction strategy that asks bidders to include in their proposals land acquisition, environmental impact assessments, design/engineering, public scoping sessions, furnishings from bed linens to phones, as well as construction.

Again, I thank the Subcommittee for allowing us to testify today. North Village believes that if more federal projects, even pilot projects, were opened up to logical construction competitive bidding that the taxpayer would be the beneficiary. We believe the foundation for this point of view is well grounded given the Dallas or Houston examples previously mentioned.

I would be pleased to answer any questions that you may have.

[comprehensive RFP - Houston, Texas, 667-bed State Jail,  
referenced on page 4 of North Village testimony]

04/04/1995 14:19 713-663-0915

BFETT RULE

PAGE 02

COPY

JUDICIAL DISTRICT COMMUNITY SUPERVISION  
AND CORRECTIONS DEPARTMENT  
BID COVER SHEET

REP- STATE JAIL FACILITY

RETURN NO  
LATER THAN 1:00 P.M. November 22, 1993

BIDS RECEIVED LATER THAN THE DATE AND TIME STAMPED ABOVE WILL  
NOT BE CONSIDERED

Judicial District Community Supervision and Corrections Department is  
requesting Request For Proposal - FOR : STATE JAIL FACILITY

FUND: \_\_\_\_\_

ORGANIZATION/PROGRAM: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

**VENDOR NOTE 11**

**PLEASE READ ALL INSTRUCTIONS, REQUIREMENTS AND  
SPECIFICATIONS CAREFULLY !**

**Fill Out All Forms Completely In Ink or Typewritten:**

All proposals must be submitted no later than November 22, 1993, 1:00 P.M.

Company Name: \_\_\_\_\_

TOTAL AMOUNT OF BID: \$ \_\_\_\_\_

Please submit all bids in duplicate to:

Judicial District Community Supervision and Corrections Department

Fiscal Services Section

49 San Jacinto, Room 624

Houston, Texas 77002

For additional information, contact: Karen Finlay at (713) 229-2458

FILE  
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The Harris County Community Justice Council requests eligible entities to submit Proposals for Council consideration for the implementation of Mode Two State Jail Facilities. Proposals must be for a turn-key 667 bed (or greater) facility including site, design, construction, equipment and furnishings with a target date for occupancy of October 1, 1994. Proposals will be reviewed by the Council at its scheduled meeting on November 30, 1993. The Council will review the proposals to select the most appropriate and cost effective for inclusion in the Harris County Community Justice Plan and consideration by the Texas Department of Criminal Justice for funding and implementation.

Proposals should be organized as follows:

- I. Cover Page
- II. Description of Facilities to be Constructed
- III. Site Requirements/Utility Infrastructure
- IV. Administration of Program
- V. Implementation Strategies
- VI. Benefits to the Community
- VII. Description of Incentives
- VIII. Letters of Support

#### I. Cover Page

The cover page must identify the submitting entity, Project Manager (if any), Contractor (if any) and any other parties involved in development of the proposed facility.

#### II. Description of Facility to be Constructed

The 73rd Legislature created a new class of offenders, state jail felons. This new class of offenders will be sentenced to community supervision for a period of two to five years, and as a condition of supervision, be confined in a state jail facility for up to two years.

A prototype design will be used for the construction of a 667 bed medium security unit. Specifications for the physical plant may be found in the proposed state jail standards currently published in the Texas Register for public review and comment. Copy attached.

The 667 bed prototype is intended to be a single story structure, requiring approximately 49 acres. Entities offering a proposal should indicate limitations of proposed site, in the event they cannot meet acreage requirements or elect to construct a multi-story facility. A description of the alternative plan must be identified at the time of submission.



### III. Site Requirements/Description of Site:

This section should provide a detailed description of the site. Applicants must include the following:

#### Identification of the property

Acreage

Location

Current Ownership

If property to be donated: Name of donor

If property to be purchased; Estimated purchase price

Availability of suitable utilities must be specified

### IV. Administration of Program

If proposal includes operation of the proposed facility, the following must be specified:

- A.) Identification of Program Administrator
- B.) Proposed organizational chart
- C.) Staffing patterns (including salary and benefit costs)
- D.) Proposed compliance with facility/program standards. **MUST INCLUDE LIST OF ANY WAIVERS OF STANDARDS REQUIRED**
- E.) Program description
- F.) Identification of service providers, if applicable, for both security and program components.

### V. Implementation Strategies

This section should provide timelines for step-by-step implementation of the program, including construction schedule (must include target dates). Required public hearings and proposed sites and dates must be included.

### VI. Benefits to the Community

A brief description of the benefits gained through the implementation of the state jail facility in the proposed location and configuration.

### VII. Description of and Incentives Offered:

Community estimates of value of incentives should be detailed, inclusive of land values.

### VII. Letters of Support

Applicants should attach copies of letters of support from local interested parties.

Mr. McCOLLUM. Thank you very much, Mr. Brys, and thank you for summarizing your testimony.

Our next witness we're going to call on—as I said, we're going to skip around because of the order of being introduced—is Dr. Thomas. So if you would proceed, please, Dr. Thomas, we're happy to have you.

**STATEMENT OF CHARLES W. THOMAS, DIRECTOR, PRIVATE CORRECTIONS PROJECT, CENTER FOR STUDIES IN CRIMINOLOGY AND LAW, UNIVERSITY OF FLORIDA**

Mr. THOMAS. Thank you, Mr. Chairman, members of the committee. I appreciate the opportunity to be here this morning.

If you have copies of my printed testimony, I think you'll find that provided you with a fairly comprehensive overview of the available research evidence coming out of the American experience with full-scale privatization of correctional facilities as well as information from the United Kingdom and Australia.

By way of putting this in some context for those of you who may be unfamiliar with trends in privatization, I would suggest that you turn the clock back to perhaps 1980. You would find that in the United States there were no privately-managed, secure adult correction facilities. Not insignificantly, other than in the Federal jurisdiction, there were no jurisdictions in the United States that had the expressed legal authority that authorized States or localities to contract with private vendors for the private management of jails or prisons.

If you fast forward to today, as you can tell from some information that is appended to my testimony, we, at the end of calendar year 1994, had a total of 88 contracts that had been awarded for the full-scale management of secure facilities and that provided, including facilities under construction, 49,154 units of capacity. That has changed already. We are now more or less in a real-time posture of having 96 facility contract awards in place. When all of that capacity is online, it will provide prisoner housing for 54,824 prisoners. Not insignificantly, that includes local, State, and Federal facilities, facilities for male offenders, for female offenders, minimum, medium, and maximum security classified facilities scattered across the United States.

To summarize as briefly as possible the information provided in the fairly lengthy testimony, I'll just tiptoe through quickly the primary points that the research literature appears to support in terms of advantages that can be realized through contracting. I take this to be largely incontrovertible evidence given the amount of information presently available.

There is no question but that the private sector is in a position to move forward with new construction projects substantially more rapidly than the typical governmental entity. Director Hawk, for example, suggested a multiyear time frame for the bringing online of new Federal facilities. It is absolutely common in the private sector for, from the date of contract execution to the date of facility opening, with a fixed-price construction contract and inclusive of everything, including environmental impact, everything to be accomplished within a period of 12 to 18 months or the firms that

receive the contracts suffer financial penalties. This includes our experience in Florida, Mr. Chairman, on State facilities.

There's no question, I think, given the available literature, that the construction cost savings are routinely in the range of 15 to 25 percent on comparable size and caliber of facilities. There's no question but that there are design efficiencies being produced by the private sector, and by design efficiency I'm thinking in terms of how the operating cost of a typical correctional facility is shaped. Perhaps 75 percent of total costs go to employee salaries and benefits. But the more efficient the design, the smaller will be the complement of full-time employees required to operate the facility in a suitably professional manner.

Operating cost savings is a separate point and routinely comes in with cost savings in the 10- to 15-percent range or higher. As was indicated by other testimony, in the long haul, about 90 percent of the costs are operating costs. If you can realize 10 to 15 percent cost savings, you're talking, even by Federal standards, about a lot of money.

We have two facilities that the chairman may be familiar with in Florida, two 750-bed facilities, privately designed and constructed. The first will open this month. Just those two facilities over the 3-year initial term of the contract are now projected to save the State of Florida \$9 million in operating costs, and that figure is certified by the auditor general of the State of Florida.

The evidence strongly supports the principle that the realization of significant cost savings is not being accomplished by reducing the overall caliber of services. The research evidence comes from both within and beyond the United States.

It is absolutely clear that contracting out for full-scale management reduces the legal liability exposure of government. It's similarly clear that contracting out—and this I'd be happy to explain, if it seems backwards—but contracting out expands rather than contracts the legal rights and remedies available to prisoners housed in these facilities.

Privatization obviously provides a means by which government can place control on the growth of, or provide for a reduction in, the total number of public employees.

There is no question, separately, that contracting out provides for a substantially more flexible means of delivering correctional services because of the ability of the private sector to expand and contract and engineer and reengineer is simply better than what we ordinarily find in government.

It also provides, I believe, a means by which government agencies can become and can remain more accountable to the taxpayers for the manner in which they expend public funds and the manner in which they have delivered services.

Now all of these advantages have been recognized for the last 3 or 4 years. There is no question that each of the Federal agencies that has prisoner custody responsibilities—the INS, the U.S. Marshals Service, and the Federal Bureau of Prisons have significant experience with contracting. If you browse through, I believe it's pages 21 through 24 of my formal testimony, there is a listing of the kinds of problems that I perceive Federal agencies have encountered, though I hope that some of those problems will be over-

come in the future. Bottom line for the problems is that Federal agencies have handled their procurement responsibilities in something less than an exemplary manner, and the less-than-exemplary manner has taken a God-awful lot of time. I've seen Federal procurement processes take twice as long to move from start to finish on consequentially large facilities for the procurement processes take twice as long as it did to go from bare dirt to a key in the lock of a completed facility—2 years to do the procurement, one year to go from beginning to end on construction. Something is wrong with that picture.

There are opportunities, I think, available to you. I think that Director Hawk is moving forward vigorously. I think if there are problems in the Federal jurisdiction, the problems would include a conservative estimate of the scope and range of activities that the private sector is now in a position to handle. They certainly could benefit from moving forward more swiftly and more aggressively.

There are some opportunities independent of the Federal Bureau of Prisons that I believe some of you might be inclined to support. You raised, Mr. Chairman, the Lorton issue. There is abundant reason to believe that, if that was a federalized set of facilities, that the entire Lorton complex, including the needed expansion, could be contracted out at quite a substantial savings to the taxpayers. I also think that you have opportunities which I identify in the formal testimony if you were to have the opportunity to amend H.R. 667 by providing incentives to the States to capitalize on some of the advantages of the privatization that I've alluded to.

I'd be happy to answer any questions that you might have.

[The prepared statement of Mr. Thomas follows:]

**PREPARED STATEMENT OF CHARLES W. THOMAS, DIRECTOR, PRIVATE CORRECTIONS PROJECT, CENTER FOR STUDIES IN CRIMINOLOGY AND LAW, UNIVERSITY OF FLORIDA**

Good morning, Mr. Chairman. My name is Charles W. Thomas, and I very much appreciate this opportunity to testify before the Subcommittee on Crime of the House Committee on the Judiciary.

By way of a brief personal introduction, I am a Professor of Criminology in the Center for Studies in Criminology and Law at the University of Florida. I also am the Director of the Private Corrections Project at the University of Florida; a consultant to the Florida Correctional Privatization Commission, which has contracted for the private design, financing, construction, and management of six state prisons since it was established in 1993; a member of the Corrections and Sentencing Committee of the American Bar Association; and a member of the American Correctional Association. Additionally, I have testified before and/or served as a consultant to numerous county commissions, state legislative committees, state correctional agencies, and federal agencies. My work in those various capacities was related to such objectives as the drafting of legislation to authorize the full-scale management of correctional facilities by the private sector, the preparation of competitive procurement documents, the drafting of correctional facility management contracts, and the evaluation of the performance of private corrections management firms.

You invited me to testify this morning in my capacity as the Director of the Private Corrections Project at the University of Florida. In accepting this invitation I appear as neither an opponent nor a proponent of correctional privatization, and I have no personal economic interest that would be advanced or undermined by any decisions Congress might make regarding this issue. This neutrality, however, does not mean that I have no predispositions. My position is simple. I am persuaded that it is the obligation of government to provide for the delivery of the best possible public services at the lowest possible cost and to do so with the public or private identity of the service provider being defined as fundamentally irrelevant absent compelling constitutional reasons that government alone must provide the service under consideration.<sup>1</sup>

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<sup>1</sup>It is my judgment that obvious and relevant illustrations of such compelling reasons exist with regard to such inherently governmental functions as the enactment of criminal law, the adjudication of guilt or innocence in criminal cases, the imposition of criminal sanctions, final decisions regarding material changes in the conditions of confinement that have implications for

As will be established by my testimony, there is clear and convincing evidence emerging from within and beyond the boundaries of the United States that applying this simple standard has regularly and routinely supported decisions to privatize. This body of evidence, however, provides no support for any hypothesis that contracting out is necessarily or inherently a better policy than preserving traditional methods of delivering correctional services. Instead, rather like the comparison shopping prudent individual consumers of goods and services accept as a necessary element of their economic behavior, government serves the public interest when its choices between alternative providers of essential services are based on balanced considerations of the cost and quality of services the selected providers will be obliged to deliver rather than their public or private status.

In any event, my purpose will be to provide you with a concise overview of the most timely and objective information that is available regarding the rapidly growing role of the private sector in the design, financing, construction, and management of secure adult correctional facilities. My opinion is that this review will raise your confidence that past and present privatization initiatives of the Federal Bureau of Prisons, and also related efforts of the Immigration and Naturalization Service and the U.S. Marshals Service, reflect the sound professional judgment I have come to expect from these federal agencies and can be depended upon to serve the public interest. Indeed, my hope is that your collective confidence will raise to such a point that you will recommend moving beyond the ambitious plan that has been announced by President Clinton and Director Hawks and, in your individual legislative capacities, that you will capitalize on the opportunities you have to encourage state- and local-level privatization initiatives via appropriate amendments to such pending legislation as H.R. 667, the Violent Criminal Incarceration Act of 1995.

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the liberty interests of prisoners, and final decisions regarding release from confinement. However, it is my further judgment that it is settled law that a private entity, subject to appropriate checks and balances, can be empowered to manage and operate correctional facilities of any kind.

It is convenient to organize my presentation by focusing on three topics: (1) the history of the full-scale privatization of secure adult correctional facilities, (2) evidence regarding the degree to which the anticipated benefits of contracting out are being realized; and (3) my recommendations regarding how those working at the federal level can both maximize the benefits of contracting and avoid some of the problems that have been encountered in the past.

### *I. An Overview of the History of Correctional Privatization*

Critics of privatization contend that there is nothing new or novel in the involvement of private persons or corporations in our correctional systems. So long as the point is being made at quite an abstract level, the critics are correct. More than one period of penological history has found government permitting and sometimes encouraging private jailers to exploit and abuse prisoners.<sup>2</sup> As recently as the 1920s, for example, both Alabama and Florida were involved in convict lease arrangements with private firms that yielded significant financial benefits to both the firms and the coffers of the jurisdictions.<sup>3</sup> Often, however, the critics imply or assert that there is little to prevent the abuses of the past from rematerializing in the present. Any such implication or assertion must be evaluated in terms of the fundamental changes that have transformed relevant portions of the correctional landscape since the 1920s. At least two of these changes deserve emphasis.

The more purely legal side of the equation is easily summarized. Prior to, during, and even for some decades after policies that authorized such things as convict leasing systems, the courts routinely refused to inject themselves into the operation of correctional facilities. The "hands-off doctrine" announced in the 1891 decision of the Virginia Supreme Court in *Ruffin v.*

<sup>2</sup>See, e.g., Thorsten Sellin, *Slavery and the Penal System*, New York: Elsevier, 1976; William Cohen, *Negro Involuntary Servitude in the South, 1865-1940: A Preliminary Analysis*, 42 *The Journal of Southern History* (1976); Alex Lichtenstein, *Good Roads and Chain Gangs in the Progressive South: 'The Negro Convict is a Slave.'* 59 *The Journal of Southern History* (1993).

<sup>3</sup>See, e.g., Sean McConville, *Aid from Industry? Private Corrections and Prison Crowding*, pp. 221-242 in Stephen D. Gottfredson and Sean McConville (Editors), *America's Correctional Crisis: Prison Populations and Public Policy*. New York: Greenwood Press, 1987.

*Commonwealth*, 21 Grat. 790 (Va. 1891), a decision that reflected legal perceptions of the role of prisoners during the first half of the twentieth century, was quite matter-of-fact:

[A prisoner] has, as a consequence of his crime, not only forfeited his liberty, but all his personal rights except those which the law in its humanity accord him. He is, for the time being, the slave of the State.

The hands-off doctrine did not survive the judicial activism of the 1960s. In particular, a set of decisions announced by the United States Supreme Court in such landmark cases as *Monroe v. Pape*, 365 U.S. 167 (1961), and *Monell v. Department of Social Services*, 436 U.S. 658 (1978), transformed 42 U.S.C. § 1983 from a largely dormant provision of federal civil rights law into the dominant force it is today. Most easily understood as the civil enforcement mechanism for the Due Process Clause of the Fourteenth Amendment, § 1983 provides a cause of action for any person, including any prisoner, who confronts a deprivation of a constitutional right as a consequence of "state action."<sup>4</sup> Under the more recent holding of the Supreme Court in *West v. Atkins*, 487 U.S. 42 (1988), private persons providing constitutionally-mandated services under contract for local and state correctional agencies are subject to suit under § 1983. Further, prisoner plaintiffs who satisfy the "prevailing party test" forged by the Supreme Court in such cases as *Hensley v. Eckerhart*, 461 U.S. 424 (1983) can recover reasonable attorney fees under 42 U.S.C. § 1988. Further still, elsewhere I have noted in some detail that it is settled law that the array of equitable and legal remedies now available to prisoners housed in private correctional facilities is broader than is the set of remedies made available to their counterparts in public facilities.<sup>5</sup>

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<sup>4</sup>Members of the Subcommittee will immediately understand that 42 U.S.C. § 1983 is generally unavailable to plaintiffs who allege that federal officials proximately caused a constitutional deprivation, but they will also appreciate the degree to which the remedy crafted by the Court in *Bivens v. Six Unknown Named Agents of the Federal Bureau of Narcotics*, 403 U.S. 388 (1971), is functionally equivalent in most regards when "federal action" rather than "state action" is at issue. See also, *Davis v. Passman*, 442 U.S. 228 (1979); and *Carlson v. Green*, 446 U.S. 14 (1980).

<sup>5</sup>See, e.g., Charles W. Thomas, *Prisoners' Rights and Correctional Privatization: A Legal and Ethical Analysis*, 10 *Business and Professional Ethics Journal* (1991).



The effect of these and related changes in correctional law has been to dramatically alter the position in which prisoners find themselves. No longer cast in the powerless role of slaves of the State, they can and do aggressively litigate their claims of having been treated unreasonably. This is true without regard to whether they are housed in publicly or privately managed correctional facilities.

On the structural side of the equation, facility contracts---whether by statute, contractual provisions, or a combination of the two---prohibit private corrections management firms from deriving financial benefits either by charging prisoners a fee for the services they receive or by exploiting the labor of prisoners for their own benefit. In and of itself, this change in the relationships contracts establish between government, private management firms, and prisoners reduces the probability of many of the abuses that characterized private involvement in corrections previously.

In short, the context within which private corrections firms operate today is fundamentally dissimilar to that of previous periods of history. Thus, it is not mere coincidence that recent history yields no evidence of a disregard for the rights of prisoners housed in privately-managed facilities that is even remotely similar to what was witnessed previously.

Regarding the modern era, by which I mean the early 1980s and thereafter, the obstacles proponents of correctional privatization had to overcome were formidable. The sins of the past had certainly not been forgotten. No legislation in the nation expressly authorized any unit of government to contract with a private entity for the full-scale management of a secure adult correctional facility. There was no tangible evidence that the private sector had delivered on any promise of lower correctional costs without a corresponding decrease in the caliber of correctional services. Significant organizations---including but not necessarily limited to the American Bar Association, the American Civil Liberties Union, the American Federation of State, County, and Municipal Employees, the American Jail Association, and the National Sheriffs Association---were quick to oppose and sometimes to be stridently critical of early privatization initiatives.

The effect of such obstacles to contracting was that the emergence of a private corrections industry involved a step-by-step process rather than a swiftly adopted innovation. The process began in the early 1980s with modest contract awards by the Immigration and Naturalization Service and the U.S. Marshals Service to such pioneering firms as Behavioral Systems Southwest and Eclectic Communications, Inc.<sup>6</sup> Practically speaking, however, the privatization alternative did not attract serious attention until several key developments materialized during the mid-1980s. Specifically, the first county-level awards of management contracts came in 1984, when Hamilton County (Chattanooga), Tennessee, and in 1985, when Bay County, Florida, awarded contracts to the Corrections Corporation of America. The first state-level contract award came in 1985, when Kentucky contracted with the U.S. Corrections Corporation. The first sizable federal award came in 1984, when the Immigration and Naturalization Service contracted with the Corrections Corporation of America for the Houston Processing Center. The first contract awards on the international scene are of even more recent vintage, the first coming in 1989 from the State of Queensland, Australia to the Corrections Corporation of Australia and the first non-Australian award coming in 1991 from the United Kingdom to Group 4 Prison and Court Services, Ltd.

The importance of these contract awards to the subsequent development of correctional privatization would be difficult to over-estimate---and the fact that all six contracts are still in force today with the same management firms is not inconsequential. Each provided a real world opportunity to test the hypothesis that contracting could yield meaningful benefits to government. Each also provided an invaluable model that subsequent units of government could examine and improve upon in such critical areas as the formulation of sound contracts and effective means of contract monitoring. That these early contracting decisions contributed to a rapid increase both in the willingness of legislative bodies to authorize contracting and in the willingness of government agencies to contract is confirmed by the materials presented in

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<sup>6</sup>Behavioral Systems Southwest no longer operates secure adult correctional facilities. Eclectic Communications, Inc. now operates as a wholly-owned subsidiary of Cornell Cox, Inc.

Appendix A, Figure 1,<sup>7</sup> which graphically depicts growth in the rated prisoner capacities of private correctional facilities, and Appendix A, Table 1, which summarizes the results of a national survey of legal authority to contract for the private management of secure correctional facilities.<sup>8</sup>

Put somewhat differently, the role of the private sector in the management of secure adult correctional facilities is strikingly different today than it was in the early 1980s. At that time no American jurisdiction enjoyed the expressed legal authority to contract and no such management contracts had been awarded. Today, as is illustrated by Appendix A, Table 1, 32 states, Puerto Rico, and the District of Columbia have the statutory authority to contract at the local and/or state levels and that each of the three federal agencies that have prisoner custody responsibilities has comparable legal authority to contract.<sup>9</sup> Further, as is summarized by Appendix A, Table 2, at the end of 1994 there were 19 private firms which had received contracts to operate secure adult facilities, the number of contract awards now in place, including facilities now under construction, provided for 88 facilities with a rated capacity of 49,154 prisoners.<sup>10</sup> Sixty-seven facilities with an aggregate rated capacity of 30,821 and an actual prisoner population of 28,678

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<sup>7</sup>The statistical information relied upon to create this graphic was derived from two sources: Corrections Corporation of America, *Crime and Punishment: 1993 Annual Report*, Nashville, Tennessee: Corrections Corporation of America (1994), at p. 11; and Editions 1-8 of Charles W. Thomas, *Private Adult Correctional Facility Census*, Gainesville, Florida: Private Corrections Project, University of Florida.

<sup>8</sup>The process relied upon to gather data regarding legal authority to contract involved a computerized screening of all applicable statutes and attorney general opinions and telephone contacts with representatives of departments of correction and/or attorney general offices.

<sup>9</sup>The "and/or" language is important. Although logic might suggest that the legal acceptability of contracting by one level of government within a jurisdiction implies that other levels of government enjoy the legal authority to contract, this is not the case.

<sup>10</sup>The American jurisdictions within which secure private facility contracts are either in place or are under construction are Alabama, Arizona, California, Colorado, Florida, Kansas, Kentucky, Louisiana, Mississippi, New Mexico, New Jersey, New York, Oklahoma, Puerto Rico, Rhode Island, Tennessee, Texas, Utah and Washington. Significantly, however, the fact that private facilities are in operation or are under construction in these jurisdictions does not mean that local or state agencies have contracted for the housing of prisoners. The facilities in New Jersey, New York, Rhode Island, and Washington, for example, do not house local or state prisoners on behalf of these jurisdictions. Further, other jurisdictions are contracting for the housing of their prisoners in out-of-state rather than within-jurisdiction private facilities (e.g., Alaska, North Carolina, and Virginia).

are already in operation.<sup>11</sup> Finally, when the correctional privatization movement emerged during the early 1980s it was widely believed that any role of the private sector in the management of secure adult correctional facilities would be limited to small facilities housing prisoners with low security classifications. Today it is common to see contract awards for facilities with rated capacities of between 1,000-2,000 prisoners and for those prisoners who have security classifications at or above the medium security level.<sup>12</sup>

This historical evidence makes it abundantly clear that the appeal of contracting for the management of secure facilities continues to gain momentum and that the appeal has reached beyond the boundaries of the United States. The evidence strongly implies but does not prove that a prudent policy maker can have confidence in the ability of the private sector to forge productive partnerships with government with the shared goal of meeting the many challenges that now face the nation's correctional system. Thus, it is important to shift the focus of my testimony from general historical trends to a consideration of whether the weight of the best available research evidence establishes contracting out as a meaningful alternative to traditional strategies for delivering correctional services.

## *II. Research Evidence Regarding the Full-Scale Privatization*

I would be foolish were I to attempt to review each and every dimension of the rapidly growing volume of research evidence on correctional privatization. Fortunately, some of what we know is so matter-of-fact that little or no discussion is required. Relevant illustrations of this would certainly include but not necessarily be limited to the following:

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<sup>11</sup>The first half of 1995 already has witnessed significant contracting activity on both the national and international scenes. New projects underway in the United States include two in Texas with an aggregate capacity of 2,500 beds and three in Florida with an aggregate capacity of 1,050 beds.

<sup>12</sup>It is worth noting that the first private facility designed exclusively for maximum security-classified prisoners was designed and constructed by the Corrections Corporation of America, began receiving prisoners in June of 1992, received full accreditation by the American Correctional Association in August of 1993, and, as has been the case from the beginning, is dedicated to meeting the needs of the U.S. Marshals Service.

- that contracting out can reduce the time required to construct new facilities to between 12-18 months;
- that contracting out can reduce total costs for new facility construction (i.e., site acquisition, facility design, site preparation, and purchase of necessary furnishings, fixtures, and equipment) by 15-25 percent;
- that contracting out can yield facility designs which are significantly more efficient than those often selected by public agencies (i.e., designs that allow the delivery of a full range of services in a professional manner with as small a number of employees as is reasonably possible);
- that contracting out allows government to decrease the total number of public employees or at least to decrease the rate of growth in the number of public employees;
- that contracting out allows government to decrease quite substantially the legal liability exposure which is associated with the operation of correctional facilities;
- that contracting out allows government decision makers to increase, to decrease, or to modify the array of services provided within correctional facilities more swiftly and more flexibly than is possible when services are provided by public employees; and
- that contracting out, largely because it involves a set of contractually-based terms and conditions, increases the ability of government agencies to be accountable for programs and expenditures.

By and large, at least, the debate over correctional privatization has not focused on these potential advantages of contracting out. Instead, the two areas that have stimulated the greatest interest flow from two claims that privatization proponents have advanced since the early 1980s. One claim is that the private sector can provide government with significant operating cost savings throughout the terms of contracts. The other claim is that the private sector can provide

government with corrections services the scope and quality of which are equal to if not better than those provided by government agencies.

Privatization opponents have attacked both claims. If, the opponents argue, the private sector does devise means of providing government with operating cost savings, then it necessarily follows that the economies will be realized at the expense of the caliber of programs and services prisoners receive, the qualifications of the employees who provide those programs and services, or both. Because statutory and/or contract requirements so routinely oblige private firms to employ persons who meet or exceed all applicable experience, certification, and training requirements their public sector counterparts must meet, the position of the critics is generally reduced to the simpler contention that any reduction in operating costs will cause a reduction in the quality of the services private firms provide. Thus, these potentially interrelated concerns deserve careful attention.

#### *Does Contracting Out Yield Meaningful Cost Savings?*

By far the weakest challenge to correctional privatization comes from those who contend that contracting is unlikely to yield significant cost benefits. The initial reasons why the challenge lacks credibility are at least three-fold. First, the very fact that a contract exists strongly suggests the contracting governmental entity was confident that cost savings would be achieved. During a decade of personal experience with contracting, I have yet to encounter a single unit of government that was willing to contract without having first been assured of cost savings. Indeed, it is not uncommon to see tangible evidence of cost savings being cast as a statutory precondition for contract awards.<sup>13</sup> Second, regardless of whether one considers private corrections management firms or substantially any other type of private entity, it is generally acknowledged that private sector fringe benefits---most particularly retirement benefits---are less generous than those made available to public employees.<sup>14</sup> Third, the private

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<sup>13</sup>An illustration of this is provided by a Texas statute that precludes contract awards absent an assurance of operating cost savings of at least 10 percent.

<sup>14</sup>It does not necessarily follow that the retirement package private firms make available to their employees will yield a less advantageous set of actual retirement benefits. For example, the appeal of qualified employee stock ownership plans (ESOPs) within the private corrections

sector is not obliged to comply with a broad array of costly bureaucratic requirements government has imposed upon itself in such areas as employee selection-promotion-termination and the procurement of goods and services. Consequently, a reasonable person ought to be surprised only if he or she encountered a contracting initiative that failed to yield at least some cost savings.<sup>15</sup>

In short, the real question is how great the cost savings of contracting are likely to be rather than whether there will be any cost savings. Unfortunately and, when one recognizes that efforts to reduce costs have been a driving force behind privatization efforts, surprisingly, sound evidence regarding the magnitude of cost savings is not abundant. As recently as 1987, for example, a report prepared by The Council of State Governments and The Urban Institute observed that "we have not found available reliable cost information at any of the levels of government studied here."<sup>16</sup> Since then, however, a good deal of evidence has been published.<sup>17</sup>

industry is growing. To be sure, the number of dollars flowing toward an ESOP in a given year is almost certain to be smaller than the number of dollars flowing toward a government retirement trust fund for an equivalent employee during the same year. However, the success of the firms that elect ESOP-based retirement programs for their employees might well yield such an appreciation on the value of the shares held for those employees that the financial value of the private employees' retirement package would be greater than the financial value of defined benefit retirement plan public employees have come to expect.

<sup>15</sup>It is worth noting that evaluations of the precise magnitude of cost savings is exceedingly difficult to determine. The core problem is that substantially all governmental accounting systems are incapable of capturing total expenditures. One major reason for this is that service delivery agencies operating within government depend in varying degrees on services provided by other agencies for an array of services (e.g., accounting services, data processing services, some or all legal services, management of retirement systems, and so on). The cost of these so-called off-budget services are real. However, one very seldom sees them being reflected in correctional agency estimates of construction or operating costs.

<sup>16</sup>Judith Hackett, Harry Hatry, Robert B. Levinson, Joan Allen, Keon Chi, and Edward D. Feigenbaum, *Issues in Contracting for the Private Operation of Prisons and Jails*. Washington, D.C.: The Council of State Governments and The Urban Institute, 1987, at p. 124.

<sup>17</sup>See, e.g., Charles H. Logan and Bill W. McGriff, *Comparing Costs of Public and Private Prisons: A Case Study*, 216 NIJ Reports (1989); *The Urban Institute, Comparison of Privately and Publicly Operated Correctional Facilities in Kentucky and Massachusetts*, Washington, D.C.: National Institute of Justice (1989); Sandra E. Albright and Fran Harchas, *Private Prison Management in Louisiana: A Cost Analysis*, unpublished manuscript (1990); Doctor R. Crants, III, *Private Prison Management: A Study in Economic Efficiency*, 7 *Journal of Contemporary Criminal Justice* (1991); General Accounting Office, *Private Prisons: Report to the Chairman, Subcommittee on Regulation, Business Opportunities and Energy, Committee on Small Business, United States House of Representatives* (1991); Texas Sunset Advisory Commission, *Recommendations to the Governor of Texas and Members of the 72nd Legislature* (1991); Douglas C. McDonald, *The Costs of Operating Public and Private Correctional Facilities*, pp.

Reflecting both the sophistication of the cost comparison methodologies relied upon and various other factors,<sup>18</sup> the results of the cost savings analyses vary quite broadly from study to study. Four illustrations based on conservative approaches warrant special emphasis here.

The first study was conducted by Charles H. Logan and Bill W. McGriff and published by the National Institute of Justice.<sup>19</sup> Logan and McGriff compared the actual contract cost paid to the Corrections Corporation of America for operating the 350-bed Hamilton County Penal Farm located near Chattanooga, Tennessee between 1985 and 1988 with estimates of what Hamilton County would have paid had it continued to operate the facility itself. The estimates were based on actual 1983-84 expenditures plus annual employee salary increases equal to those actually received by Hamilton County employees and non-salary increases equal to inflation as measured by the Consumer Price Index. The total estimated costs for continued public management of the facility for the three-year period was \$9,909,717 and the total actually paid to the Corrections Corporation of America during the three-year period was \$9,404,801. Thus, Logan and McGriff concluded that the total cost savings realized by contracting was \$504,917, or an average annual operating cost savings of 5.37 percent. Significantly, this cost savings was possible despite the fact that public operating costs estimated for the three-year period averaged only \$26.08 per prisoner per day, a per diem cost which was itself well below the reported average per diem cost of roughly comparable facilities elsewhere in Tennessee.<sup>20</sup> Further, the

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86-106 in Douglas C. McDonald (Editor), *Private Prisons and the Public Interest*, New York: Rutgers University Press, 1990.

<sup>18</sup>An often-ignored illustration of the factors that influence cost savings appears to involve nothing more or less than the per prisoner per day costs government was willing to tolerate prior to contracting decisions. All other things being equal, the higher the costs paid by government prior to contracting, the greater will be the cost savings realized by contracting. For example, Crants, *id.* at p. 57, reports that Santa Fe County, New Mexico was paying a relatively high \$75.00 per prisoner per day prior to awarding a management contract to CCA in 1986 that provided for a per diem payment of \$44.50 and thus yielding an estimated operating cost savings of 40.7 percent.

<sup>19</sup>Charles H. Logan and Bill W. McGriff, *Comparing Costs of Public and Private Prisons: A Case Study*, 216 NIJ Reports (1989).

<sup>20</sup>This point warrants special emphasis and some additional interpretation. First, some correctional systems in the United States are reporting operating costs that are well below national and applicable regional averages. The degree to which a private firm can yield large operating cost economies in such areas is consequentially lower than one might expect to see flowing from contracts awarded by agencies with comparatively high operating costs. Second, it



authors emphasized that the conservative methodology they relied upon almost certainly resulted in their underestimating the true cost savings to Hamilton County.<sup>21</sup>

The second study deserving special attention was published by the Texas Sunset Advisory Commission in 1991 and was designed to determine whether contracts awarded to the Corrections Corporation of America and to the Wackenhut Corrections Corporation by the Texas Department of Criminal Justice in 1988 had achieved the 10 percent cost savings required by applicable Texas law.<sup>22</sup> The contracts required each firm to design, construct, and manage two 500-bed minimum security prisons. The cost methodology called for the Sunset Advisory Commission to determine what the cost to Texas would have been in 1990 had the four prisons been operated by the TDCJ and to compare that estimate with the actual payments made to CCA and WCC. The results reveal an average estimated cost for public operation of the facilities of \$42.92 and an actual payment to CCA and WCC of \$36.76. The resulting savings of \$6.16 per prisoner per day or \$4,496,800 per year for all four facilities yields an estimated cost savings of 14.35 percent.<sup>23</sup>

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must be understood that there is nothing magical about contracting out for facility operations which automatically gives rise to major economies. Indeed, there is evidence that there are some well-managed correctional systems within which careful comparisons of public and private operating costs result in findings of rather modest savings being realized by privatization initiatives. See, for example, Tennessee Select Oversight Committee on Corrections, *Comparative Evaluation of Privately-Managed Corrections Corporation of America Prison (South Central Correctional Center) and State-Managed Prototypical Prisons (Northeast Correctional Center, Northwest Correctional Center)*. Nashville, Tennessee: Tennessee Select Oversight Committee on Corrections (February, 1995).

<sup>21</sup>See, for a further explanation of this point, Charles H. Logan, *Proprietary Prisons*, pp. 45-62 in Lynne Goodstein and Doris Layton MacKenzie (Editors), *The American Prison: Issues in Research and Policy*. New York: Plenum Press, 1989.

<sup>22</sup>Texas Sunset Advisory Commission, *Recommendations to the Governor of Texas and Members of the 72nd Legislature* (1991). It is worth noting that there is evidence which suggests that the cost advantage of the private facilities in Texas is persisting. A recent report released by the Texas Criminal Justice Policy Council as is required by applicable Texas statutes estimates the average cost per prisoner per day in Texas to have been \$44.40 during FY 1994 versus an estimated private facility cost per prisoner per day of \$35.25. Texas Criminal Justice Policy Council, *Texas Correctional Cost Per Day, 1993-94*. Austin, Texas: Texas Criminal Justice Policy Council (February, 1995).

<sup>23</sup>In large part on the strength of this cost analysis, the TDCJ recently awarded four additional contracts for the private design, construction, and management of 500-bed prisons.

Third, Allan Brown, an economics professor at Griffith University in Brisbane, Australia, has provided a recent and well-documented examination of whether the American experience is generalizable beyond the United States.<sup>24</sup> The relevant portion of his research focuses on a two-year cost comparison of a public and a private correctional facility in Queensland. The Borallon facility is operated by the Corrections Corporation of Australia; the Lotus Glen facility is operated by the government correctional agency. Both facilities were recently constructed, and are similar in their design, and are similar in the size and security classification of their prisoners. Importantly, Brown's cost data included various overhead costs that often escape attention when only facility expenditure data are available. Although Brown noted that "Borallon [the private facility] provides the highest programme content of any correctional centre in Queensland and employs a much greater number of staff on programmes than does Lotus Glenn [the public facility]," the gross annual cost per prisoner for 1991-92 at Borallon was \$39,240 versus \$54,560 for Lotus Glenn and the gross annual cost per prisoner for 1992-93 at Borallon was \$44,200 versus \$49,880 at Lotus Glenn.<sup>25</sup>

The final and certainly one of the more thorough illustrations comes from Florida. During its special legislative session in 1993, the Florida Legislature enacted what is now Chapter 957 of the Florida Statutes. The new law provided for the creation of the Florida Correctional Privatization Commission and imposed an obligation on the Commission to release a request for proposals providing for the private design, financing, construction, and management of two 750-bed medium security prisons.<sup>26</sup> To assure the desired cost savings, Chapter 957

<sup>24</sup>Allan Brown, *Economic (and Some Non-Economic) Aspects of Prison Privatisation in Queensland*, paper presented at the 1994 Conference of Economists, Surfers Paradise, Australia, 1994.

<sup>25</sup>Annual costs are expressed in Australian dollars. A portion of the difference in cost for each facility between the first and second years is caused by a difference in the means of allocating central office overhead costs. However, even if one focuses exclusively on facility costs and ignores the troublesome task of estimating off-budget costs, the cost comparison still favors the private facility.

<sup>26</sup>It should be noted that the author has served as a consultant to the Florida Correctional Privatization Commission since 1993. The information provided in the text was derived from his reviews of Commission files and interviews with the Executive Director of the Commission. All of the information, however, is a matter of public record pursuant to applicable provisions of Florida law.

required the Florida Auditor General to determine the total cost Florida would incur for the design, construction, and operation of comparable state facilities. Significantly, the Auditor General was expressly obliged to incorporate a full array of costs in the establishment of the required benchmark figure. Thus, the Auditor General's report examined construction and operating costs at multiple comparable facilities being operated by the Florida Department of Corrections, indirect costs associated with central management of the Florida Department of Corrections, and additional indirect costs associated with services provided to the Florida Department of Corrections by various other state agencies.<sup>27</sup> The statute required that cost proposals submitted by private management firms yield cost savings of no less than 7 percent as a precondition to any contract award.

A request for proposals was released by the Florida Correctional Privatization Commission in December, 1993. Each interested private firm was allowed to submit a proposal for one or both of the 750-bed facilities. All proposals had to be submitted by early February, 1994. Eight management firms submitted a total of twelve proposals. All twelve proposals contained legally binding commitments of cost savings that met or exceeded the 7 percent requirement. Two firms were selected at the end of the competitive process: the Corrections Corporation of America and the Wackenhut Corrections Corporation. The CCA and WCC costs, including debt service obligations associated with facility construction, were, respectively, \$46.96 and \$47.05. The comparable cost for the Florida Department of Corrections was \$52.40. On average, then, there is credible evidence that these contracting decisions by the State of Florida will yield an average cost savings of \$5.39 per prisoner per day. Assuming a conservative occupancy rate of 90 percent during the first year of operation of these facilities, the anticipated first year cost savings will thus be \$2,655,923. Furthermore, the terms of these three-year contracts were structured in such a way as to guarantee that the initial cost savings would persist for the life of the contract. Thus, if the occupancy rates in both facilities reach and remain

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<sup>27</sup>State of Florida, Office of the Auditor General, *Certification of Correctional Facility Actual Per Diem Costs Pursuant to Section 957.07, Florida Statutes* (November, 1993).

at facility capacities and if the initial assurances prove to be realities, Clayton Mark Hodges, the Executive Director of the Florida Correctional Privatization Commission, believes that these contracts will save Florida taxpayers modestly more than \$9,000,000 during the first three years of facility operations.

In short, today no well-informed critic of privatization contends that contracting will yield no significant savings. Instead, they advance the "you get what you pay for" argument and allege that discounted prices will necessarily yield substandard services. If this claim were proven to be valid, then contracting clearly would fall into the category of decisions that are "penny wise but pound foolish." Thus, the available evidence regarding the quality of services provided by private corrections management firms deserves serious consideration.

### **Does Contracting Out Result in Decreased Service Quality?**

Like beauty, perhaps quality is to be determined only in the mind of the beholder. Still, significant evidence now exists regarding the quality of contract services.<sup>28</sup> This evidence uniformly supports a conclusion that efforts to achieve cost savings by contracting do not undermine the goal of providing high caliber correctional services. There are at least four types of evidence.

The first indicator is as broad---and perhaps as crude---as it is pragmatic. It evaluates quality by measuring the willingness of contracting units of government to renew existing

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<sup>28</sup>The shifting focus of the privatization debate urged by privatization critics is troublesome to many. In the early 1980s critics predicted that neither government nor prisoners would tolerate full-scale management of secure facilities by management firms. When history proved them to be wrong, they restated their position and predicted that contracting would yield no meaningful cost savings. When history proved them to be wrong, they again restated their position and predicted that contracting would necessarily yield substandard correctional services. The evidence about to be reviewed in the body of the text proved them to be wrong yet another time. Today one encounters further changes in the critique of privatization involving predictions that a sufficiently long-term assessment of contract performance will yield negative results. Such adjustments are too often put forward in such a way that it is impossible for the predictions to be falsified by empirical evidence. Negative research can always be dismissed with claims that evidence supportive of the critical hypotheses is just beyond the horizon. Clearly, however, if policy analysis is to inform policy making, then policy analysts simply must perform in a more sophisticated manner. Predictions from both privatization opponents and proponents that are framed in such a way that they defy confirmation or disconfirmation are altogether uninformative.

contracts. The hypothesis is that contracts would be terminated for cause or not renewed if contracting units of government were dissatisfied with either the cost savings being realized or the caliber of the services being provided by independent contractors.

Evaluated in this manner, it appears that the satisfaction of government is considerable. A review of contracts awarded for the management of secure adult facilities since the privatization movement began to gather momentum in the mid-1980s reveals the closing of only one facility in Zavala County, Texas for reasons related to inadequate contract performance and one contract in Sweetwater, Texas being shifted from one private management firm to another for roughly comparable reasons. Not insignificantly, neither of the management firms involved in these situations are presently involved in the management of adult correctional facilities.<sup>29</sup> Additionally, the review reveals only one contract in California that was not renewed because of cost considerations, but in that one situation the cost issue was linked to the terms of a property lease with a third party that were beyond the control of both the private firm and the involved

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<sup>29</sup>This fact warrants at least some passing emphasis. Competition for facility management contract awards is nothing if not intense. If government plays its role competently---which is to say if government places balanced emphasis on both the cost and the quality of correctional services and thereby precludes the success of "low-ball" bids being successful---then the competition between the firms that comprise the private corrections industry will do much to undermine the financial viability of underperforming firms that are in or that attempt to enter the industry. Efforts to achieve this judicious balance present government with some of the most challenging problems it ever confronts as a purchaser of either goods or services. First, if obtaining the best possible goods or services at the lowest possible cost is what allows government to become a "smart buyer" and government wishes to achieve that status, then government seeks a status it cannot achieve in the absence of fair competition between alternative suppliers. This invites the inclusion of less than demanding requirements in procurement documents regarding corporate qualifications, credentials, and financial strength and creates the possibility that inexperienced, undercapitalized firms will receive contracts. If, however, this potential problem is avoided, then other problems can easily surface. All other things being equal, the growth achieved by successful competitors tends to allow a progressively smaller number of competitors to achieve such superior positions that true competition between alternative providers becomes less and less possible. The resulting monopoly one company may come to enjoy or the oligarchy a few companies are able to form can thoroughly undermine the movement of government toward smart buyer status. Thus, it seems self-evident that the key to becoming a smart buyer in the field of corrections or elsewhere is in the formulation of sophisticated requests for proposals and equally sophisticated methods for evaluating submissions by competing firms. Contrary views notwithstanding, the hard reality is that there is no language one can inject into contracts or techniques one can incorporate into contract monitoring strategies that can compensate for poorly crafted procurement documents or weak evaluations of submissions.

contracting agency. Thus, the best available data fail to reveal a single contract awarded to any firm now a part of the private corrections industry that has been terminated or not renewed for reasons related to the caliber of contract performance.

The second indicator is similarly broad and equally pragmatic. It focuses on litigation experience of the private corrections management firms. A recent and reasonably careful review of the circumstances of all privately managed jails and prisons in the United States fails to reveal a single facility that is operating under a consent decree or court order as a consequence of suits brought against it by prisoner plaintiffs.<sup>30</sup> When one recognizes that roughly three-quarters of American jurisdictions now have major facilities or their entire systems operating under consent decrees or court orders and that similar intervention by the courts is hardly uncommon in local correctional systems,<sup>31</sup> the fact that private facilities remain unblemished by successful prisoner suits is not trivial.

The third indicator is based on independent assessments of compliance with the standards of the Commission on Accreditation for Corrections of the American Correctional Association. To be sure, the correlation between accreditation status and caliber of services provided is imperfect. There are facilities that have not sought accreditation within which one finds sound services; there are accredited facilities which are far from exemplary on one or more dimensions. At the same time, however, there is much to be said in favor of those correctional facilities that are willing to shoulder the substantial burdens associated with seeking accreditation and that are willing to accept the risks associated with independent professional assessments by ACA audit teams. Thus, it is significant that private firms have walked successfully down the accreditation path far, far more often than have their public sector counterparts.

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<sup>30</sup>This does not mean that no private facilities are operating under court orders or consent decrees that are applicable to the correctional systems of which they are a part. It does mean that I have found no evidence of a private firm having entered into a consent decree or being placed under a court order as a consequence of a finding of unconstitutional jail or prison conditions in a facility for which it was responsible.

<sup>31</sup>See, e.g., American Correctional Association, *Directory of Juvenile and Adult Correctional Departments, Institutions, Agencies, and Paroling Authorities*. Laurel, Maryland: American Correctional Association, 1994, at p. xx.

The final indicator comes from the growing body of research literature that has examined the quality of privately provided correctional services.<sup>32</sup> Certainly the most sophisticated of these reports is one published recently by Charles H. Logan. Based on data from institutional records and modified versions of the Prison Social Climate Survey developed by the Federal Bureau of Prisons, Logan gathered detailed data on the quality of confinement in the New Mexico Women's Correctional Facility being operated by the Corrections Corporation of America, the Western New Mexico Correctional Facility that housed New Mexico's female prisoners prior to the opening of the CCA facility in 1989, and the Federal Correctional Institution in Alderson, West Virginia. The study included 333 empirical indicators designed to measure eight different aspects of the quality of confinement. His overall conclusion was simply summarized: "The private prison outperformed the state and federal prisons, often by quite substantial margins, across nearly all dimensions."<sup>33</sup>

Logan's general conclusion that private corrections management firms are fully capable of providing high caliber correctional services gains significant support from another longitudinal evaluation research project the results of which were published earlier this year by the Tennessee Select Oversight Committee on Corrections. The task before the Select Oversight Committee was to determine whether a contract award made to the Corrections Corporation in 1991 met the following statutory renewal preconditions: "After the first two (2) years of operation, but before renewing the initial contract, the performance of the contractor shall be compared to the performance of the state in operating similar facilities...The contract may be renewed only if the contractor is providing at least the same quality of services as the state at a

<sup>32</sup>Robert B. Levinson, *Okeechobee: An Evaluation of Privatization in Corrections*, 65 *Prison Journal* (1985); Judith Hackett, Harry Hatry, Robert B. Levinson, Joan Allen, Keon Chi, and Edward D. Feigenbaum, *Issues in Contracting for the Private Operation of Prisons and Jails*, Washington, D.C.: The Council of State Governments and The Urban Institute, 1987; Samuel J. Brakel, *Prison Management, Private Enterprise Style: The Inmates' Evaluation*, 14 *New England Journal on Criminal and Civil Confinement* (1988); *The Urban Institute, Comparison of Privately and Publicly Operated Correctional Facilities in Kentucky and Massachusetts*, Washington, D.C.: National Institute of Justice (1989); Charles H. Logan, *Well Kept: Comparing Quality of Confinement in Private and Public Prisons*, 83 *Journal of Criminal Law and Criminology* (1992).

<sup>33</sup>Logan, *id.*, at p. 601.

lower cost, or if the contractor is providing services superior in quality to those provided by the state at essentially the same cost."<sup>34</sup>

To satisfy this statutory requirement the Select Oversight Committee selected two state-operated facilities of comparable design and mission and gathered a large volume of data on virtually all aspects of facility operation during the course of the two-year research project. Although the private facility cost per prisoner per day was modestly lower than the comparable cost for the two state facilities (\$35.76 for the state facilities versus \$35.38 for the private facility), the private facility received a higher overall rating than the two public facilities.<sup>35</sup> This, in turned, prompted a renewal of the facility management contract.

In summary, the best of the available evidence provides no support for the hypothesis that the cost saving strategies of private management firms undermine the caliber of the services provided in the facilities for which they are responsible. To the contrary, it is common for jurisdictions that have contracted for the private management of correctional facilities to report that the overall caliber of the services provided have improved in their scope and quality.

### III. Recommendations for Federal Action

If your reading of the growing research literature on full-scale correctional privatization correlates well with mine, then several relevant conclusions will be clear. Contracting with private corrections firms for the design, financing, construction, and management of all types of secure adult correctional facilities has emerged as a viable alternative to traditional means of

<sup>34</sup>TENN. CODE ANN. §41-24-105(c) and §41-24-105(d).

<sup>35</sup>Tennessee Select Oversight Committee on Corrections, *Comparative Evaluation of Privately-Managed Corrections Corporation of America Prison (South Central Correctional Center) and State-Managed Prototypical Prisons (Northeast Correctional Center, Northwest Correctional Center)*. Nashville, Tennessee: Tennessee Select Oversight Committee on Corrections (February, 1995). Importantly, all three facilities had very high overall evaluation scores and the difference between the highest and lowest rated facility was only 1.32 points. This indication of sound performance at all three facilities is supported by the accreditation scores each received during the audit conducted by the American Correctional Association. Although there, too, the private facility had the highest score (99.29), both public facilities received very high marks (98.78 and 98.88).



delivering correctional services. Contracting can yield meaningful benefits by increasing the swiftness with which new correctional capacity can be made available, by decreasing construction costs, by enhancing the flexibility government enjoys when the need arises to add new services or modify the nature of previously provided services, by elevating the accountability of contracting agencies for both their expenditures and their programs, by decreasing legal liability exposure, by decreasing facility operating costs, and by preserving or improving upon the caliber of correctional services government agencies provide.

Naturally, the degree to which a particular government agency realizes these benefits depends on a broad array of factors that are at least somewhat under the control of the agencies (e.g., its awareness of its own costs inclusive of the so-called "off-budget" expenses, the character of regulatory and statutory influences that shape procurement options, the sophistication with which it approaches procurement processes, the sophistication of contracts, the quality of contract compliance monitoring.) It also depends to some measure on factors that are less subject to agency control (e.g., the existence of a sufficient level of competition between experienced providers of services). Fortunately, all three federal agencies that have prisoner custody responsibilities have significant experience in the contracting arena. For example, sixteen of the eighty secure private facilities now in operation or under construction in the United States are primarily or exclusively committed to meeting the needs of one or more federal agencies. Unfortunately, while not always a consequence of factors over which any individual agency had control, not all federal contracting efforts have been exemplars of how one can simultaneously maximize the benefits and minimize the risks of contracting.

#### *Problems Associated with Some Past Federal Contracting Initiatives*

Explaining why criticism of some past federal contracting initiatives is deserved would require more time than is available this morning. However, several historical problems seem fairly obvious.

First, it would be fair to say that there previously has been little enthusiasm for fundamental change among the senior echelons of the Department of Justice, and this has been

more apparent in the Bureau of Prisons than in the Immigration and Naturalization Service and the U.S. Marshals Service. The adoption and effective diffusion of innovations is difficult unless unequivocal signals are sent to middle-management by its executives, and I am hopeful that the leadership now being provided by Director Hawks will yield meaningful benefits.

Second, I believe some federal agencies, certainly including the Bureau of Prisons, can fairly be said to have been overly conservative in their definitions of what the private sector is qualified to do. The present plan to focus on contracting only for pre-trial detention facilities and for housing space for prisoners with minimum and low security classifications is at least illustrative of this point.

Third, I often have been critical of the frequency with which federal agencies have engaged in non-competitive procurement when the need for contract housing space materialized. Although there surely are circumstances that support reliance on Intergovernmental Agreements, it remains true that properly structured competitive procurement processes provide a better assurance that contracts will yield the best possible services at the lowest possible cost.

Fourth, I have even more often been critical of the awkwardness of over-specification I have seen in federal procurement documents. Some agency personnel seem unable to avoid the temptation to go far beyond appropriate descriptions of what services their agencies wish to secure and into the realm of detailed descriptions of how those services are to be provided. A "do it the way we do it" posture significantly undermines opportunities to invite and encourage creativity.

Fifth, some federal contracting decisions strike me as having erred in the direction of being so influenced by costs that they neglected to recognize that contracting for value presupposes a judicious balance between cost and quality considerations. I understand the temptation. Nonetheless, a key to successful contracting is understanding the costs and quality of services federal agencies now provide and contrasting that information with the costs and quality of services private corrections firms propose. No productive long-term purpose will ever be served if cost proposals alone shape contracting decisions.

Sixth, I continue to be perplexed and often frustrated by the snail's pace at which federal procurement processes often move. Earlier, for example, I observed that I am a consultant to the Florida Correctional Privatization Commission. Until the Florida legislature enacted Chapter 957 of the Florida statutes during its special legislative session in the summer of 1993, we had no such agency. However, within approximately six months of the hiring of Clayton Mark Hodges, the Executive Director of the Commission, we had prepared and released a Request for Proposals aimed at contracting for the design, financing, construction, and management of two 750-bed medium security prisons, received and evaluated voluminous submissions from eight vendors, and drafted and executed two lease-purchase agreements, two construction contracts, and two facility management contracts. The first of these facilities is scheduled to receive prisoners in mid-June of this year---less than two years after the original version of the new Florida statute was drafted and with the professional staff of the Correctional Privatization Commission consisting entirely of the Executive Director, a handful of professional consultants, and the efforts of an attorney who had a full-time assignment to an unrelated state agency. By contrast, I observed a smaller procurement effort launched by the Bureau of Prisons for a single 1,000-bed facility require more time than this merely to move from its release of a Request for Proposals to the execution of a final contract---and I then observed Concept, Inc. move from contract to execution to the construction and opening a new facility in only twelve months and do so at a construction cost far, far below that of comparable federal facilities.

Sixth, Congress itself would be prudent to raise questions regarding the degree to which the efficiency and effectiveness of privatization initiatives are being undermined by existing federal statutes and regulations. The present legal context as it has been interpreted by federal agencies erects obstacles to private firms which require access to the capital markets if they are to obtain funds for the construction of new correctional facilities. Illustrations of this include the short-term nature of contracts, differing interpretations regarding the number and duration of contract renewals, the general absence of assurances that contracting agencies will utilize no less than a fixed proportion of the prisoner housing space contract facilities make available, and

uncertainties regarding the circumstances under which periodic increases in operating cost per diems will be possible. These obstacles have the unintended but negative effect of both increasing total project costs and decreasing the number of qualified firms which elect to compete for federal contract awards.

*Opportunities for Congressional Action*

There are an almost limitless number of opportunities associated with correctional privatization which Congress could pursue with the reasonable assurance that pursuing them would simultaneously protect the public safety interest, allow federal agencies to realize significant construction and operating cost savings, control the growth in the number of federal employees, and assure the delivery of high caliber correctional services. Perhaps the most obvious of these that is of local interest would be the ability of Congress to resolve a major problem confronting the District of Columbia in a cost effective manner by relying on the private sector rather than the Bureau of Prisons to assume responsibility for the Lorton complex.

Although I believe Congress could and should carefully evaluate the very real benefits that would flow from contracting out for necessary renovations, expansion, and management of the Lorton complex, a different opportunity is one to which I would assign even greater potential. The opportunity is presented by H.R. 667 and S. 3, both of which propose amendments to the Violent Crime Control and Law Enforcement Act of 1994. The version of H.R. 667 I recently reviewed provided for grants of more than 10 billion dollars to states or multi-state compacts that meet various eligibility standards associated with applicant sentencing policies for persons convicted of violent crimes. In effect, of course, the language of H.R. 667 offers a meaningful financial incentives to jurisdictions that adopt sentencing policies that correlate with policies Congress perceives to be effective means of protecting the public safety interest.

Given the state of the best available evidence, I believe it would be entirely appropriate for Congress to amend the language of H.R. 667 in such a way as to encourage state-level privatization initiatives of the same ambitious type as those recently announced in the federal jurisdiction by Director Hawks. Eligibility standards, for example, could include suitable proof

that applicant jurisdictions have enabling legislation which authorizes full-scale privatization and/or a commitment on the part of applicant jurisdictions which obliges them to commit at least some portion of any federal grant funds they receive to the private design, financing, construction, and management of new correctional facilities---if, of course, the results of procurement efforts provide evidence that contracting out would yield cost savings without a reduction in the caliber of correctional services.

#### IV. Conclusions

By way of concluding remarks I will be concise and direct. There was a time not so very long ago when advocates of correctional privatization had little to support their claims that the private sector could manage secure adult correctional facilities efficiently and effectively than beyond the firmness of their convictions. There were no private corrections management firms. There were no privately-managed facilities. There could be no supportive evidence unless and until some government agencies were driven by necessity or by faith to contract.

Those early days of the correctional privatization movement have passed. The cautious experiments we saw then set the stage for the confidence we see today in jurisdictions all across the nation as well as in Australia and the United Kingdom. The confidence does not flow from necessity or from faith. It flows instead from a growing body of hard evidence. The evidence demonstrates that properly sophisticated privatization initiatives can and do yield an array of benefits that include but are not limited to significant construction and operating cost savings as well as the delivery of correctional services whose caliber is at least equal to those provided by government agencies in contracting jurisdictions.

The conclusion a prudent policy maker should draw is as clear as it is unavoidable. To the degree that such a policy maker is motivated to guarantee the delivery of the best possible correctional services at the lowest possible cost, then he or she can and should promote correctional privatization whenever doing so is appropriate. Importantly, the evidence offers

abundant proof that the scope of what deserves to be viewed as appropriate is quite broad. It is no longer true that privatization is a viable alternative only for those whose focus is on relatively small facilities intended to house prisoners with low security classifications. Instead, today there are few or no types of correctional facilities operated by government that do not have equivalent counterparts that are operated by the private sector. Thus, today the true challenge to elected officials and correctional agencies is not to determine whether decisions to privatize correctional facilities are defensible policy decisions. The challenge is to devise fair and sophisticated procurement strategies that maximize the benefits of contracting and to develop management models that facilitate the diffusion of innovations developed by the private sector into the operation of facilities operated by public agencies.

Notwithstanding some of the reservations I have expressed about past contracting by federal agencies, you and your colleagues in Congress have just cause to be confident about the future of contracting at the federal level. The Bureau of Prisons, and also the Immigration and Naturalization Service and the U.S. Marshals Service, have attracted some of the most talented and professional people the field of corrections has to offer. Their reputation across the nation and on the international scene is without equal. With your and their leadership, my hope and my belief is that the immediate future will bring model partnerships between the public and private sectors.

Table 1: Research Findings Regarding Legal Authority to Contract for Secure Adult Facilities

Jurisdiction	Source of Local-Level Contracting Authority	Local-Level Contract(s) Awarded?	Source of State-Level Contracting Authority?	State-Level Contract(s) Awarded?
Alabama	Statutory Interpretation	Yes	None Identified	No
Alaska	N/A	N/A	Expressed Statutory	Yes, for out-of-state facilities
Arizona	Expressed Statutory	No	Expressed Statutory	Yes
Arkansas	Expressed Statutory	No	Expressed Statutory	No
California	Expressed Statutory	Yes	Expressed Statutory	Yes
Colorado	Expressed Statutory	No	Expressed Statutory	Yes
Connecticut	N/A	N/A	None Identified	No
Delaware	N/A	N/A	None Identified	No
District of Columbia	Statutory Interpretation	Yes	N/A	N/A
Florida	Expressed Statutory	Yes	Expressed Statutory	Yes
Georgia	Statutory Interpretation	No	None Identified	No
Hawaii	N/A	N/A	None Identified	N/A
Idaho	None Identified	No	None Identified	No
Illinois	Statutory Prohibition	No	Statutory Prohibition	No
Indiana	None Identified	No	None Identified	No
Iowa	Statutory Interpretation	No	Statutory Interpretation	No
Kansas	Statutory Interpretation	Yes	None Identified	No
Kentucky	Expressed Statutory	Yes	Expressed Statutory	Yes
Louisiana	Expressed Statutory	Yes	Expressed Statutory	Yes
Maine	Negative Attorney General Opinion	No	None Identified	No
Maryland	Statutory Interpretation	No	Statutory Interpretation	No
Massachusetts	None Identified	No	None Identified	No
Michigan	None Identified	No	None Identified	No
Minnesota	Expressed Statutory	No	Statutory Interpretation	No
Mississippi	Negative Attorney General Opinion	No	Expressed Statutory	No
Missouri	Negative Attorney General Opinion	No	Negative Attorney General Opinion	No
Montana	Expressed Statutory	No	Expressed Statutory	No
Nebraska	Expressed Statutory	No	Expressed Statutory	No

Table 1: Research Findings Regarding Legal Authority to Contract for Secure Adult Facilities

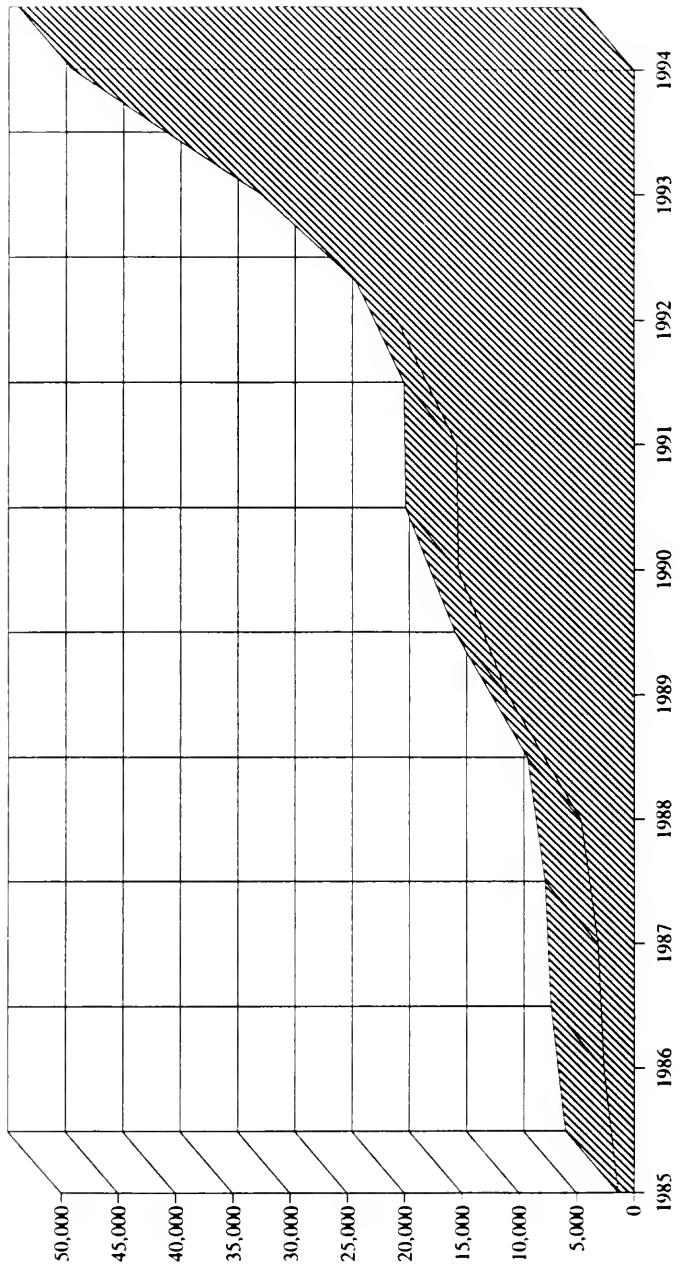
Jurisdiction	Source of Local-Level Contracting Authority	Local-Level Contract(s) Awarded?	Source of State-Level Contracting Authority?	State-Level Contract(s) Awarded?
Nevada	None Identified	No	Expressed Statutory	No
New Hampshire	None Identified	No	Expressed Statutory	No
New Jersey	None Identified	No	None Identified	No
New Mexico	Expressed Statutory	Yes	Expressed Statutory	Yes
New York	None Identified	No	Statutory Prohibition	No
North Carolina	None Identified	No	None Identified	Yes, for out-of-state facilities
North Dakota	Expressed Statutory	No	Expressed Statutory	No
Ohio	Negative Attorney General Opinion	No	None Identified	No
Oklahoma	Expressed Statutory	No	Expressed Statutory	No
Oregon	None Identified	No	None Identified	No
Pennsylvania	Statutory Interpretation	No	None Identified	No
Puerto Rico	None Identified	No	Statutory Interpretation	Yes
Rhode Island	N/A	N/A	None Identified	No
South Carolina	None Identified	No	Statutory Interpretation	No
South Dakota	Expressed Statutory	No	None Identified	No
Tennessee	Expressed Statutory	Yes	Expressed Statutory	Yes
Texas	Expressed Statutory	Yes	Expressed Statutory	Yes
Utah	Expressed Statutory	No	Expressed Statutory	Yes
Vermont	Expressed Statutory	N/A	None Identified	No
Virginia	Negative Attorney General Opinion	No	Expressed Statutory	Yes, for out-of-state facilities
Washington	None Identified	No	None Identified	No
West Virginia	Expressed Statutory	No	Expressed Statutory	No
Wisconsin	None Identified	No	None Identified	No
Wyoming	Expressed Statutory	No	Expressed Statutory	No



Table 2: Profile of Private Corrections Industry on 12/31/94

Management Firm	Rated Capacity of All Facilities Under Contract*	# Facilities Under Contract	Rated Capacity of Facilities Now In Operation	Prisoner Populations on 12/31/94	% Occupancy for Facilities In Operation	New Facilities to Open within 12-18 months	Expansion Anticipated Within 12-18 Months
Alternative Programs, Inc.	240	1	240	240	100.00%	0	0
The Bobby Ross Group	872	1	872	751	86.12%	0	0
Capital Correctional Resources	836	1	836	664	79.43%	0	0
Concept, Inc.	4,426	8	2,926	2,825	96.55%	2	1,500
Cornell Cox, Inc.	794	3	794	777	97.86%	0	0
Corrections Corporation of America	14,965	24	10,264	9,579	93.33%	5	4,701
Corrections Partners, Inc.	1,891	3	584	606	103.77%	1	1,307
Corrections Services, Inc.	32	1	32	29	90.63%	0	0
Dove Development Corporation	762	2	762	621	81.50%	0	0
Eden Detention Center	1,006	1	710	700	98.59%	0	296
Essex Correctional Services, Inc.	1,170	4	1,170	1,236	105.64%	0	0
Group 4 Prison & Court Services, Ltd.	680	2	680	410	60.29%	0	0
The GRW Corporation	100	1	100	100	100.00%	0	0
Management & Training Corporation	2,640	4	900	882	98.00%	2	1,740
Mid-Tex Detention, Inc.	1,297	3	744	704	94.62%	1	553
North American Corrections	489	1	489	439	89.78%	0	0
U.S. Corrections Corporation	2,918	6	1,650	1,625	98.48%	2	1,268
The Villa at Greeley, Inc.	400	1	0	0	N/A	1	400
Wackenhut Corrections Corporation	13,636	21	7,068	6,490	91.82%	7	6,568
TOTALS	49,154	88	30,821	28,678	93.05%	21	18,333
% Changes Since 12/11/93	50.99%	20.55%	24.55%	28.73%	3.64%	61.54%	134.74%

*Figure 1: Ten-Year Growth in Bed Capacity of Privately-Managed Secure Adult  
Correctional Facilities*



Mr. McCOLLUM. You've done a good job of summarizing very extensive and exhaustive testimony, Dr. Thomas. Thank you for coming and presenting it.

Mr. THOMAS. Thank you.

Mr. McCOLLUM. Dr. Shapiro, I think you're next in our order. Please proceed.

**STATEMENT OF STUART H. SHAPIRO, M.D., PRESIDENT AND CEO, PRISON HEALTH SERVICES, INC.**

Dr. SHAPIRO. Thank you very much for inviting me to testify today.

My name is Stuart Shapiro. I'm a medical doctor and president and CEO of Prison Health Services. As the name implies, we provide health services at prisons and jails across the United States. We've been providing these services since 1978. We're currently providing services in approximately 100 State and county or city facilities, and just last month we were awarded a contract to provide health care to 35,000 inmates for the entire State of Georgia.

The Federal Government spends big dollars on health care, and so I'm very pleased today to have the opportunity to explain how privatizing the health care system in the Federal Bureau of Prisons with experienced, high-quality, managed health care providers can save a billion dollars over 5 years without any loss of control in the quality of health care for the Bureau of Prisons. That \$1 billion was actually calculated before Director Hawk spoke today. I just did a back-of-the-envelope calculation of what the additional cost savings would be between the base price that we've been able to do it at and the price to the BOP based on a projection of the number of inmates that the Bureau will have in 5 years. And just on those new prisoners, just on the new prisoners, in addition to the billion dollars, I calculated almost \$100 million a year would be saved between its current costs by the Bureau of Prisons and what is being done by a private contractor.

Over the last 15 years, hundreds of State and local jurisdictions have successfully made transitions to privatizing their correctional health system.

PHS, Prison Health Services, is an HMO behind bars and, as such, we provide services at a predetermined level at a predetermined price and assume all liabilities. In fact, the movement toward privatization has moved so extensively that almost all members of the full Judiciary Committee represent a State that uses private correctional health care firms in its prisons or local jails.

My role today will be to separate some fact from fiction regarding privatization, and despite this demonstrated success at the State and Federal levels, the Federal Government has yet to take advantage of privatized health care in its prisons in a meaningful way. Let's talk some facts.

The costs of providing health care to about 100,000 inmates confined in Federal prisons are staggering, and we've seen them increase dramatically. In 1988, the Bureau of Prisons spent \$86 million on health care for an average of just under \$2,000 per inmate. In 1994, only 6 years later, the Bureau of Prisons is spending over \$3,200 an inmate per year on health care. Put another way, since 1988, the Bureau of Prisons inmate population increased by 117

percent and the cost of health care 250 percent, or more than double the rate.

On a per-inmate basis—and this gets at a question that Mr. Buyer mentioned earlier—there have been studies done by the Texas controller's office that said health care in the Bureau of Prisons was much higher than every State except Florida, and the GAO has done a report and said that privatization ought to be seriously looked at. Those studies have been done.

Contracting with firms specializing in correctional health care is not new. It's just not in the lexicon of the Federal Bureau of Prisons. Beginning in the 1970's, State and local governments began to seek alternative ways to provide services in a number of areas where they could retain control and still have cost savings. Health care was one of those. And, in fact, since 1978, more than 40 percent of the largest jails in America and 25 percent of the State prisons throughout the country have their health care privatized. Today hundreds of State and local governments are doing this, and over 400,000 inmates will be very shortly under privatized managed health care services.

Contracting with managed health care companies saves many, many dollars, and as I indicated earlier, we do it at a predetermined price and assume all liability. In addition, by offering a greater range of health care services and by managing care and eliminating unnecessary procedures, we reduce transportation and security costs associated with offsite health care visits. As a result of such proactive, aggressive management, we are able to provide savings to the State of Maryland, to the State of Kansas, to the city of Philadelphia of hundreds of millions of dollars.

It's interesting to note that the State and local governments are now providing health care to its prisoners at rates that the Bureau of Prisons did it in 1988, 6 years ago. Many in the Federal Bureau of Prisons have opposed privatization and, in so doing, have raised the number of very misleading and false arguments, which I'd like to put on the table very briefly to take them off the table.

First, they say inmate health care costs in the Federal prison systems are competitive with expenditures in the private sector. That's true, but that's not really the comparison that ought to take place. What are other State and local governments paying? The fact of the matter is that PHS, and our competitors, are providing care for under \$2,000 annually.

Secondly, they've also talked about and raised the question that we don't include transportation costs and catastrophic costs. That, again, is not true. In the State of Georgia the catastrophic costs are included; in the Maryland, likewise. So the fact of the matter is it's an apples-to-apples comparison. It's \$2,000 or less compared to \$3,200 in the Federal Bureau of Prisons.

I also might add that we use only licensed personnel. I might add that we place ads all the time for certified physician assistants, the category that Dr. Hawk talked about, and we get responses all the time from foreign medical graduates who are unlicensed who want to come to work for us, and we can't hire them because we only use licensed personnel. Many of these individuals have jobs in the Federal Bureau of Prisons today. So it's my belief, unless they're telling us something that's not true, that the Federal Bureau of

Prisons still is using foreign medical graduates as clinical assistants where we—and, again, it was looked at as a cost comparison issue—we use only licensed personnel; State of Georgia, \$56 million contract per year for 35,000 inmates. You can do the mathematics. The dollars are clear, and we utilize only certified personnel.

Finally, all of the BOP's new minimum and low security facilities and pretrial detention centers appear likely to be contracted out for services, including health care. Frankly, that's a very good start, but we'd suggest that you move much quicker. This goes beyond the whole issue of whether you want to privatize construction, whether you want to privatize the whole industry. This is a quick program that can work quickly and effectively. Privatization has been tested for 15 years. Many States near Washington are successfully privatized. Maryland is very successful. Pennsylvania is very successful. Delaware is very successful. Virginia is moving in that direction, and this is a highly successful program that can save dollars.

Let me just conclude by saying what an HMO behind bars, such as Prison Health Services, can do for the Federal Bureau of Prisons. The concept of managed health care is already familiar to the millions of Americans who have switched their own health care insurance from traditional indemnity plans to HMO's, and I might add that the Congress is pushing Medicaid in that direction, and I believe quite rightly so, across the country.

HMO's in the private sector have been shown to save money and simultaneously improve the quality of care. Likewise, as an HMO behind bars, companies such as Prison Health Services have saved hundreds of millions of taxpayers' dollars at the State and local level and can offer the Bureau of Prisons the same opportunity to provide quality at reduced and fixed costs. Private contracting will save the Bureau of Prisons, we believe, \$2,000 per inmate each year in direct and inmate health care costs, and just on the current population over 5 years, that's \$1 billion.

Mr. Chairman and members of the committee, these savings will free up scarce dollars for the core mission of the Bureau of Prisons: secure corrections, which otherwise would literally be wasted on inefficient health care. At this time when both the administration and Congress are seeking to reinvent the Federal Government, as many local and State governments have done, I encourage you to make privatization of prison health care services part of that solution.

Again, I thank you for the opportunity to share my comments with you today and offer to lead you, any members of your staff, to our facilities or our competitors' facilities to see what privatization can do and can do effectively.

I'm happy to answer any questions. Thank you.

[The prepared statement of Dr. Shapiro follows:]

PREPARED STATEMENT OF STUART H. SHAPIRO, M.D., PRESIDENT AND CEO, PRISON  
HEALTH SERVICES, INC.

Mr. Chairman and Members of the Subcommittee

Thank you for inviting me to testify before you today. My name is Stuart Shapiro. I am a medical doctor and President and CEO of Prison Health Services, Inc. (PHS), which is based in New Castle, Delaware. Since 1978, PHS has provided managed health care services to more than 100 state prisons and local jails across the country.

I am pleased to have this opportunity to explain how privatizing the health care system in the Federal Bureau of Prisons with experienced, high quality, managed health care providers can save taxpayers \$1 billion over the next five years, without any loss of control or reduction in the quality of health care provided by the Bureau of Prisons. Over the last 15 years, hundreds of state and local jurisdictions made successful transitions in privatizing their correctional health care systems, while simultaneously improving quality and saving billions of taxpayer dollars.

In fact, nearly all members of the full Judiciary Committee represent a state that uses private correctional health care firms in its prisons and local jails. PHS, for instance, currently contracts with state and local governments in Florida, Illinois, New York, North Carolina, Tennessee, Georgia, California, and Pennsylvania, among others. Other providers have contracts in states such as New Mexico, Ohio, Virginia, Texas, Colorado, South Carolina, and Massachusetts.

Despite demonstrated success at the state and local levels, the federal government has yet to take advantage of privatized health care in its prisons.

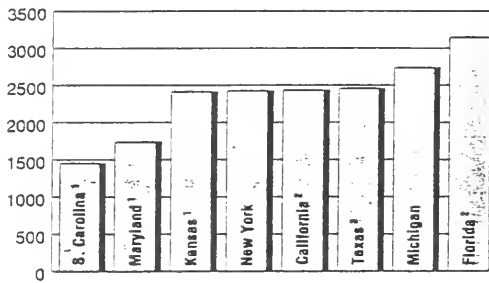
#### **The Problem: Rising Costs For Federal Bureau of Prisons Health Care**

The costs of providing health care to the more than 95,000 inmates confined in federal prisons are staggering, and have been increasing dramatically. In 1988, the BOP spent \$86 million on direct inmate health care. At the time, the BOP housed 43,835 inmates. Therefore, the BOP spent about \$1,962 per inmate in 1988. Today, the BOP spends almost \$300 million for medical care -- over \$3,200 per inmate. Put another way, since 1988, the BOP inmate population increased by 117%. Over the same time period, direct inmate health care expenses increased by 249%. As a percentage of the total BOP operating budget, medical care costs have increased from 9.3% in 1988 to over 12% today. These costs will continue to skyrocket for several reasons:

- ◆ The federal inmate population is growing by more than 10 percent a year.
- ◆ The federal inmate population is aging, thereby requiring more health services.
- ◆ The incidence of chronic diseases (such as AIDS) among inmates is increasing.

On a per inmate basis, health care costs for the BOP are substantially higher than most state health care costs. Indeed, according to an April 1994 report by the Texas Comptroller's Office, of the eight states with the largest state prison populations, only Florida's health care costs per inmate came close to the amount spent on federal prison health care.

**Exhibit 5**  
**Prisoner Health Care Costs in Several States**



<sup>1</sup> These states have implemented managed care.

<sup>2</sup> These states have historically higher community health care costs than Texas.

<sup>3</sup> Texas costs are based on \$2711, less \$252 for security staff in psychiatric units.

Source: TPR telephone survey.

Source: Texas Performance Review Behind the Walls, The Price and Performance of the Texas Department of Justice, April 1994.

After looking at Texas' prison health care costs, the State Comptroller's Office predicted: "In the future, [Texas' prison] managed health care plan will contract with external health-care providers . . ."<sup>1</sup> This year, the State of Texas has begun to do just that.

The U.S. General Accounting Office (GAO) was similarly positive in its assessment of privately-managed prison health care. In a February 1994 report on the BOP health care delivery system, the GAO indicated that "at least 15 states provide all or part of their health care to inmates through private contractors" and that the BOP should consider adopting such an approach.<sup>2</sup>

Texas Performance Review Behind the Walls, The Price and Performance of the Texas Department of Criminal Justice, April 1994

<sup>2</sup> United States General Accounting Office. Bureau of Prisons Health Care, Inmates Access to Health Care is Limited by Lack of Clinical Staff, February 1994



### Why States and Localities Have Privatized Prison Health Care

Beginning in the 1970s, state and local governments began to seek alternatives, such as contracting out and privatizing some prison and jail functions, in order to control rising costs. Management of health care services provided to inmates has grown tremendously in recent years. Since 1978, more than 40 percent of the largest jails and 25 percent of state prisons throughout the country have privatized their health care services. **Today, hundreds of state and local governments, and more than 300,000 inmates around the country, are served by private managed health care firms** such as PHS.

Much like the BOP, many state prison systems were burdened by direct health care costs of \$3,000 to \$4,000 per inmate per year prior to privatization. PHS estimates that other, hidden costs related to the delivery of health care services -- such as the cost of providing security for off-site health care visits and defending health care related lawsuits -- add another 50% to the direct health care costs. In other words, total costs, including both direct expenses of providing health care services plus related, indirect costs, bring the total expenditure to as much as \$4,500 to \$6,000 per inmate per year in non-privatized settings.

Contracting with managed care companies such as PHS saves prisons and jails millions of dollars per year because **we provide services at a predetermined price and assume all liability**. PHS creates a single line item in a budget that is guaranteed not to go higher. In addition, by offering a greater range of health care services at prison sites, and by managing care and eliminating unnecessary procedures, PHS reduces the transportation and security expenses associated with off-site health care visits. As a result of such proactive, aggressive management, in 1993 **PHS was able to provide direct health care services to prisons and jails at over 100**

sites at an average annual cost of \$1,987 per inmate, while reducing other related costs by up to 50 percent.

Privitization of prison health care results in dramatic cost savings. PHS estimates that during 1993:

- ◆ In Maryland, privatization saved \$25 million in direct and indirect inmate health care costs.
- ◆ In Kansas, privatization saved \$11 million.
- ◆ In Philadelphia, privatization saved \$3 million.
- ◆ At PHS' 100 sites nationwide, privatization saved \$100 million in health care costs.

### Opponents Claims Do Not Add Up

Opponents of privatization have raised a number of misleading and false arguments:

*Claim:* Inmate health care costs in the federal prison system are competitive with expenditures in the private sector.

*Reality:* A far more relevant comparison involves health care costs at other correctional facilities. The fact is, as my company and others have proven at the state level, converting to privatized prison health care services saves taxpayers millions of dollars.

*Claim:* Private sector correctional health care providers usually do not cover certain costs associated with inmate health care such as travel, equipment, mental health and catastrophic health care expenses.

*Reality:* This claim is simply untrue. The private sector can "do it all and save money,

too.” As an example, I mentioned earlier that PHS saved Maryland taxpayers \$25 million in direct and indirect health care costs for 12,600 inmates at three Maryland state facilities. For an average annual cost of only \$1390 per inmate, PHS’s contract includes mental health care coverage, catastrophic coverage of up to \$1 million/year per inmate and emergency transportation.

**Claim:** *The federal prison system already utilizes the private sector to provide a significant portion of the health care for inmates.*

**Reality:** One thing is certain. The BOP does not contract with any private sector correctional health care firms for managed health care programs. Rather, the BOP uses outside consultants on an inefficient case-by-case basis. Under these *ad hoc* arrangements, costs are left to spiral out of control. In contrast, costs are entirely contained when a single provider, utilizing proactive, aggressive management, contracts to absorb all the costs of providing health care to the inmate population.

One of the ways PHS keeps costs down in Maryland, for example, is by minimizing outside costs like hiring consultants and caring for prisoners in community hospitals. In Maryland, such outside costs account for 22% of PHS’ budget. In contrast, the federal prison system spends upwards of 40% on outside costs.

**Claim:** *Federal prison health care staffs are trained in correctional techniques, allowing them to provide assistance in emergency situations.*

**Reality:** Private health care personnel can and do receive equivalent training. PHS has a number of contracts where our health care personnel must undergo training in corrections, and we would be happy to train our personnel to meet BOP

requirements.

*Claim: Accreditation assures that patients receive adequate health care services, and the BOP has voluntarily attained accreditation of all of its Medical Referral Centers by the Joint Commission on Accreditation of Health Care Organizations (JCAHO).*

*Reality:* Accreditation is important, which is why we have received a total of 74 Awards of Accreditation from the National Commission on Correctional Health Care (NCCCHC) for meeting the American Medical Association's "Standards for Health Services in Prisons and Jails." No other private health care contractor has achieved this number of accreditations. PHS has also obtained JCAHO accreditation for its hospital facility at the Robinson Correctional Center in Illinois.

While it is commendable that the BOP has obtained JCAHO accreditation at all six of its Medical Referral Centers, I would point out that accreditation was initially refused at the Terminal Island Center in 1993. Moreover, a 1994 GAO study was critical of the quality of BOP health care, specifically finding that inmates with special needs, including women, psychiatric patients and patients with chronic illnesses, received inadequate health care.<sup>3</sup>

*Claim: All of the BOP's new minimum and low security facilities and pretrial detention centers will be contracted out for services, including health care.*

*Reality:* This is a good start, but why not follow the lead of so many cities, counties and states by privatizing existing facilities as well. Clearly, in order for privatization to

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<sup>3</sup>GAO Report, February 1994

be truly meaningful to taxpayers (in terms of cost savings) and to inmates (in terms of improved quality of care), the BOP must take advantage of private sector health care in all of its facilities. Because of the private sector's demonstrated success at the state and local level, I'm very confident we can translate that performance to the federal prison system.

### **What an "HMO Behind Bars" Can Do For The Federal Bureau of Prisons**

The concept of managing inmate health care is already familiar to the millions of Americans who have switched their health insurance from traditional indemnity plans to Health Maintenance Organizations (HMOs). HMOs in the private sector have been shown to save money and improve the quality of health care delivery.

As an "HMO behind bars," companies such as PHS save hundreds of millions of taxpayer dollars at the state and local levels and can offer the BOP the same opportunities to provide quality services at reduced and fixed costs. Private contracting will save the BOP \$2,000 or more per inmate each year in direct and indirect health care costs. For the current federal prison population of 95,000, this cost reduction could represent a total savings of \$200 million annually. Over five years, the savings could total \$1 billion.

In conclusion, Mr. Chairman, these cost savings will free up scarce dollars for the core mission of the BOP -- secure corrections -- which otherwise would literally be wasted on inefficient health care. At a time when both the Administration and Congress are seeking to reinvent the federal government as many state and local government governments already have, I encourage you to make privatized prison health care services part of that solution.

Again, thank you for the opportunity to share my comments with you today

Mr. BARR [presiding]. Thank you, Dr. Shapiro.

If we could, before we open the session up for questions, we'd like to ask Dr. Lipton to provide his testimony, and then we'll open it up for questions. Dr. Lipton, please.

**STATEMENT OF DOUGLAS S. LIPTON PH.D., SENIOR RESEARCH FELLOW, NATIONAL DEVELOPMENT AND RESEARCH INSTITUTES, INC.**

Mr. LIPTON. Thank you, Mr. Barr. Well, thanks for inviting me. It's a pleasure to appear before you to testify what our research and experience shows can be done with treating substance abusers in prison.

Addiction treatment is a critical component of the Nation's war on drugs, and the incarceration of persons found guilty of various crimes who are also chronic substance abusers presents a propitious opportunity for treatment. It's propitious because these persons would be unlikely to seek treatment on their own, and without treatment they're extremely likely to continue their drug use and their criminality after release. And now we have cost-effective technologies that we can effectively treat them with while they're in custody and alter their subsequent lifestyles and then, subsequently, the quality of life in our community.

I wish to really share with you the genuine optimism that I feel regarding our ability to effectively treat people who normally would be deemed by conventional wisdom to be very high risk, to be irredeemable, if you will, and these are the chronic heroin and cocaine users with extensive predatory criminal histories, these high-rate addict offenders who commit 40 to 60 robberies a year, 70 to 100 burglaries a year, more than 4,000 drug transactions a year. Yet, we have reliable and consistent evidence that has substantiated more than 25 percent reduction in recidivism after treatment, a reduction of that size yielding a substantial and tangible improvement in our quality of life.

It's my intention to describe to you the success of a number of programs used in prison-based treatment of drug-abusing offenders, to share with you my impressions of drug abuse treatment in the Federal correctional program, and to give you my advice and recommendations regarding coerced treatment. These were the questions that I was asked when called by the committee.

The field of corrections has not been known for notable rehabilitative successes. I have a reputation, perhaps along with my two colleagues, Bob Martinson and Judith Wilkes, of having virtually stopped the field of rehabilitation research and rehabilitation with the publication of our book, "The Effectiveness of Correctional Treatment," which came out in 1975, which summarized all of the research that had gone from 1945 up to 1967. I come to you, therefore, as a skeptic and not as an advocate. I come to you with a view which is jaundiced.

And so when I say to you that I now see successful outcomes for correctional programming, and see it sustained over time and across projects, with a group of offenders who otherwise would be highly unlikely to succeed, it captures my attention and it ought to capture yours. When I say "success," I'm referring to reducing recidivism to a statistically-significant degree, and by "recidivism,"

I mean returning to prior forms of conduct, as measured by parole violation, as measured by arrest, by conviction, by reincarceration, by return to drug use, and by return to criminality.

I've literally looked at more studies in this area than perhaps anybody else in the country. I have a grant currently from the National Institute on Drug Abuse to pull together all of the research that's been done to test the effectiveness of any kind of correctional intervention from 1968 to the present, and we already have over 5,000 documents from all over the world, most of them in English, but I would say about maybe 10 percent in foreign tongues, particularly from Northern Europe, Germany, Sweden, Finland, Denmark, Great Britain, a few from other countries in Europe, a few from Australia and Canada.

But our work is still ongoing in that respect. I want to share with you the particular success of the Stay'n Out project in New York in reducing recidivism, the similar kinds of success experienced by the Cornerstone Program in Oregon, and by the Key-Crest Program in Delaware. And, most recently, our own program which we're running in San Diego down at Donovan Prison is having the same kind of success, and I only got those results yesterday.

You're all aware of the scope of the problem. I won't dwell on that. The extent of treatment in prisons for the most part nationally is not shameful, but it's growing very, very slowly. And considering the volume of serious drug users that are currently incarcerated, far more people should be engaged in treatment than are currently. Those figures are stipulated on pages 9 and 10 in my remarks.

The evidence that treatment works has been building. The extent of that evidence has been only really recently available. The problem was there was a long hiatus where really not much research had gone on. And although there is an accumulation now, and we're pulling it together, specifically about drug abusers, there hasn't been that much. There has been some recent research into the testing of effective methods to deal with sex offenders, to deal with other kinds of offenders, but it's only been relatively recent that there has been drug abuse treatment research.

The Stay'n Out program is one in New York. It has been in existence now almost 15 years, and it was started out as a contract program where the contract was paid for by the State Division of Substance Abuse Services, and then the State Correctional Department took it over when it was clear that obvious success was being achieved. That program is still operating. It is the model program for the country. In most States that have adopted serious intensive drug abuse treatment, they've adopted the Stay'n Out model. They've adopted it because the program has been so successful.

That success, we studied it for about 11 years and followed up people as long as nine years. So we have a considerable amount of evidence which shows that cohort after cohort of people who have entered that program have achieved the same level of success, and since then, based on recommendations that we made and others have made, that program has been expanded to include Serendipity House, which is a halfway-in/halfway-out facility that people can

come back to if they begin to show signs of failure, that continues treatment in the community and acts as a transitional resource.

The details of the Stay'n Out evaluation are presented in the testimony. I won't go into it. I just want to say that the firm conclusion of our research is that Stay'n Out is more effective than no treatment, more effective than alternative treatments such as once- or twice-a-week psychological counseling, such as milieu therapy which is done on a much less intensive basis, and that this effectiveness is particularly true for those who remain in treatment for the optimal period of nine to 12 months.

The level of reduction that we saw is robust. We see it again and again with cohort after cohort, and what really fascinating from a researcher's standpoint is that in a totally different State with a very different population, such as what exists in Oregon, the Cornerstone program, which has a similar program, has achieved almost identical results.

Now, without going into the details of that program, I do want to mention to you some very recent results from the Key-Crest program, which is in Delaware. This is a multistage program in the Delaware correctional system which utilizes the "Key," which is a TC based on the same model as Stay'n Out, and "Crest," a residential work release center for both men and women that continues the TC model out into the community. This program has achieved for its group receiving both the Key and the Crest a 94-percent success rate, which is in this field extraordinarily high. That's after 6 months, and after 18 months of intensive followup, 70 percent success rate with that same group. That is an outstanding level of success; arrest-free, 97 percent after 6 months strikes all of us as being almost unbelievable.

And so I've called and spoke to the director of that research program, and his data are open to inspection. And so I'm very pleased to hear this because it tends to support what we have said, but it adds that special dimension which is a work release program, which none of the others have, which focuses on one of the areas of failure that we saw where people did fail in Stay'n Out and Cornerstone, and that was in the vocational aspect. So here we have added the vocational aspect at the Key-Crest program in Delaware, and that seems to have made a substantial difference.

Now the programs like Stay'n Out—and Congressman Schumer was quite correct; it's about \$3,000 to \$4,000 a year now, used to be about \$1,700 a year, but inflation and so forth—it's now \$3,000 a year more than ordinary incarceration costs. So you add this dimension, and, actually, the cost of the program is essentially paid for by the success of the program within about 2 years, and that's rather extraordinary. So that the savings produced in crime-related and drug use-associated costs seem to almost mandate treatment: well, we've got to take a look at this in a serious way, and perhaps expand it into other dimensions.

Let me just say that, notwithstanding the effectiveness of the program in the institution, it is nowhere near as effective unless you have a continuity of treatment into the community with at least 6 months of continuing the program, so that people can reenter the community, the community of work and the community of relationships, still with the powerful support of the program and



its recognition of the triggers to relapse, relapse prevention, of all the temptations that are likely to occur, and be able to buffer them during this process. Now it's not to say that Narcotics Anonymous and Cocaine Anonymous and Alcoholics Anonymous are not useful programs; they are, but they are not, for these predatory, high-risk offenders, not sufficient.

Let me mention the—does that mean my time is up, sir [referring to the House bells ringing]?

Mr. BARR. Well, let's wait and see here.

If you could, Dr. Lipton, we're going to have a vote in a few moments. Maybe you could take a few minutes here to summarize and then we could recess while the Members vote, and then we'll pick right up with the questioning of the witnesses as soon as we return.

Mr. BUYER. Mr. Chairman, if you may—I mean, we've been here a long time, and these witnesses have gone pretty far on their summaries. I mean, these are 20-minute summaries. I'm going to have to leave and I will not be able to come back. So if I could be permitted to ask some questions before we leave, you have the prerogative of the Chair.

Mr. BARR. There not being any objection, Mr. Buyer, why don't we, Dr. Lipton, if we could interrupt your testimony for just a moment, since Mr. Buyer can't return, and allow him his 5 minutes of questioning right now.

Mr. BUYER. Thank you, Dr. Lipton, for your courtesy. I appreciate that.

I have to run quickly, and so let me ask two really quick questions, one of Dr. Shapiro and then of Mr. Brys.

Mr. Brys, first of all, I'm familiar with North Village Corp. and what you're doing with regard to innovation. Actually, to both of you gentlemen, having participated over the last couple of years now with regard to the Pentagon and the acquisition process and procurement reform, I always view, sometimes with a jaundiced eye, whenever anyone comes to me and says, "I have an idea on how to make a procurement process better." I always follow the dollar. So I'm always quick to look at it with a jaundiced eye.

But I want to be a very good listener, though, because we have a participatory form of government. And that's how we get to reform the system and make it better.

Let me start with you, Mr. Brys. Being a good listener, I also recognize that you have an excellent track record. When you win seven out of eight contracts in Texas, you're doing something right, and Texas must like what you're doing. And so we have a sincere obligation to listen very well as to what you're doing and how that can be applied to the Federal sector, especially with regard to procurement reform.

My question to you specifically—and you sat here, did you not, during the testimony of the Director?

Mr. BRYs. Yes. Yes.

Mr. BUYER. When you said that you wanted to refine and consolidate the procurement procedures for construction, you had stated that you, as a sole source, do land acquisition, engineering, construction, full furnishing, environmental impact statement. My question to you is: to the facility for which they're going to build

in Hawaii, are they following the model for which you have set for Texas or not?

Mr. BRYs. Well, I don't have a full briefing or understanding of exactly what they're thinking is. It sounds like they have moved toward considering proposals that bring this full package under one umbrella and under one bid and one guaranteed price. They haven't done that to date, is all I can say at this point in time. If that's the movement, it's welcomed. It's too bad it's halfway around the world, but it's welcomed, and I'm sure, if that's a test market, it would be one that a number of qualified private firms would want to look at—would want to look at.

Mr. BUYER. All right. So you would endorse, obviously, the initiatives now being taken by the Director, but we should continue in that focused—

Mr. BRYs. I would—yes, I endorse the types of things I read in their report or their budget review earlier this year of double-bunking and moving toward more of a campus-style or mix of bed types to allow more people to be housed in tighter spaces, and that directly affects the total cost of the project because every square foot of extra building that you put together typically—unnecessarily—typically will add cost.

Mr. BUYER. If you would, please, Mr. Brys, submit to us some of your recommendations for the refinement of the procurement procedures with regard to using your model in Texas as recommendations to the committee?

Mr. BRYs. I think our experience in Texas has been that the process has been one where they advertise publicly for qualified teams to submit total turnkey bids, and it's up to the bidders to find the land, the location, if that's a requirement, but typically it has been, the location, the design, all aspects that relate to public hearings, all aspects that relate to making sure environmentally we're not recommending a bad site, furnishings, total turnkey construction, all under the umbrella of one price. They give you, typically, 60 to 90 days to respond to a program. You turn in packages along with a number of other bidders. They have a team that reviews the bids, and they award a bid, and the bid is all of that under one contract and you provide it.

Mr. BUYER. Mr. Brys, would you consider making recommendations to the committee—

Mr. BRYs. Yes.

Mr. BUYER [continuing]. Changing the procedures, please?

Mr. BRYs. Yes, I would.

Mr. BUYER. I appreciate that.

Dr. Shapiro, to you—real quickly, Mr. Chairman, if I may, and I know the time is dwindling real quick—I, for the last 2 years, I served on the Republican Health Care Task Force. A lot of people in America know of my views with regard to private health care and my battles with the Clinton administration, but I also find myself in congressional oversight, when I served on the Veterans—still serve on the Veterans Committee and on the National Security Committee. Those two committees have jurisdiction over the hospitals, and VA hospitals—

Dr. SHAPIRO. I understand.

Mr. BUYER [continuing]. Which is a military system. Those committees have responsibility over the military health care delivery systems. Now in Judiciary Committee we also have the governmental system of health care with regard to prisoners.

Dr. SHAPIRO. Right.

Mr. BUYER. When I hear testimony from you as to why we should privatize particular governmental functions, I ought to cheer, but then the question that jumps into my mind, if there's any one that you all would love to have, it would be the military because they're healthy, right?

With regard to the Director's testimony, she says, in defense of the increased cost, she said that she doesn't really get the healthiest population.

Dr. SHAPIRO. Either do we.

Mr. BUYER. So what's going through my mind is she says that basically that you would exclude catastrophic illnesses, AIDS and those types of things, and, therefore, you really couldn't have privatization to take over that. I mean, you have a contract in Georgia.

Dr. SHAPIRO. Let me respond, if I may.

Mr. BUYER. Yes, please. Please, help me out.

Dr. SHAPIRO. I understand your dilemma. First, let me comment that I watch each of you and your eyes are very good listening eyes. So you were listening, and I understand your dilemma.

In the State of Maryland we provide health care under contract for under \$2,000 an inmate. The inmates are sicker. The HIV rate is much higher than 1 percent, as it is in the Federal Bureau of Prisons, and costs are still under \$2,000. We have no catastrophic limits in Maryland and are still under \$2,000 an inmate. We assume all costs. In the State of Georgia it is a similar thing, and we will run a hospital within the prison systems in Georgia, in Augusta, called Augusta Correctional Medical Institution, which is a hospital just like the Federal Bureau of Prisons hospital. We will do that. We assume all of the costs that she is talking about and there's no flim-flam. We are a publicly-traded NASDAQ company. We have been in business for 15 years. We assume the liability. If we make mistakes—

Mr. BARR. Excuse me, Dr. Shapiro and Mr. Buyer. We really need to break in just a moment here so we can go vote. We will reconvene.

Mr. Scott, did you have one quick question before we break to vote?

Mr. SCOTT. Yes, if we could. We've had drug courts, a study. Dr. Lipton, is it your opinion that if drug offenders had the opportunity to go through rehabilitation rather than prison, we'd be just as well off? And—

Mr. LIPTON. As an alternative?

Mr. SCOTT. Right. And in followup on that, is there any difference in crack and powder cocaine and your ability to rehabilitate?

Mr. LIPTON. That's a good question. In terms of crack, almost all the people that we deal with currently are cocaine users primarily. Maybe 20 percent are serious heroin users. So the data that are

now coming out are with serious cocaine users. Therefore, I'm optimistic with respect to that.

Mr. BARR. OK. We really need to break here. I apologize to kind of break in midthought here, but we have 5 minutes to vote, and we'll reconvene here in about 10 minutes then.

Thank you all.

[Recess.]

Mr. MCCOLLUM [presiding]. If we could call the subcommittee hearing back to order, I appreciate Mr. Barr chairing it briefly. We had a vote interruption and I apologize to our witnesses for that.

We don't have a lot of time left this afternoon for the hearing from the standpoint of the schedule of Congress. We're likely to get interrupted again here shortly with a vote, and I want to be fair to everybody here.

Dr. Lipton, I understand you hadn't really finished summarizing, and for a couple of minutes, if you could briefly, if you'd like to recap where you were, please do so.

Mr. LIPTON. Thank you.

Mr. MCCOLLUM. I think 1 o'clock almost literally we'll have to be out of here. If we can—there are only three of us to ask questions. We would like to ask some questions, though.

Mr. LIPTON. Well, I do want to call your attention to the—I made some notes with respect to the use of coercion to get persons into treatment. That was a question that somebody who called me to invite me, Mr. Schmitt, asked me to address.

Mr. MCCOLLUM. Well, by all means, go right ahead.

Mr. LIPTON. If you look at the scientific literature, it is really supportive of using coercion. Coercion can be judged two different ways. One is kind of forceful coercion by the legal system requiring behavior, and another way is to force people to do things by offering them incentives to do them. And, generally, the spaces for drug abuse treatment are sufficiently sparse that you don't need to force people to enter it because you quickly fill it. All you do is open the doors to it and most of it is filled.

However, all of the evidence that I have seen points strongly to the fact that legal pressure increases retention; legal pressure promotes improved results in program after program, both with men, with women, with youth, with adults. Both longitudinal studies, as well as short-term studies, point to the use of effectively bringing people into treatment using legal intervention. And then once—if you have a viable modality, if you have a potent intervention, then once you get them in, you're going to be effective with probably somewhere between 60 and 70 percent of them, and those are people who would not ordinarily be in treatment, and that's the difference.

With respect to the Federal Bureau of Prisons and my reaction to it, I sat here just about this date in 1990 when the Director then, Mr. Quinlan, spoke about the Federal Bureau of Prisons drug abuser treatment program, and it was somewhat embarrassing—he was embarrassed at that time, but the program that was announced at that time, and which has been expanded upon by Dr. Hawk, is I think an excellent program.

And the research, I happen to know the researcher who is charged with the evaluation, and I know they're proceeding in a

way which is exemplary, so that we can look forward to having some very powerful results at the end of their 5-year period.

My recommendations to the committee, there are only limited treatment resources, and I cannot foresee any vast expansion of treatment resources generally. However, I say focusing limited treatment resources on chronic heroin and cocaine users gives you much more bang for the buck because you're going to be effective not only in reducing recidivism for people, but you're going to have an impact right away on the health and safety of the community, because these are the most predatory offenders.

I recommend implementing models of prison- and jail-based treatment that have demonstrated success with these hardcore offenders, and there is accumulated evidence to draw from. Those programs are, in fact, models which now in some instances even have training components where they can bring in judges and other treatment people and wardens and people like that to train them in how to implement these kinds of programs.

You must have community-based programs to follow on. That does not necessarily mean private community-based programs. They can be elements or components of the same program continued in the community. It is much more difficult to do it, however, without parole. You've eliminated parole in many jurisdictions, and that has taken away a powerful piece of legal supervision, which tends to keep people in, in retention in the program, for the extent of the program's impact.

I cannot suggest that parole be restored because in some States which have eliminated parole they've created alternatives to parole, some kind of quasi-release status which allows people to go into work release, for example, and under supervised supervision or some—they make up terms to create a euphemism when they've eliminated parole, because there's a recognition that when you turn a guy loose from the institution, if he's not under any kind of supervision, you're apt to lose control right away.

I recommend that Federal legislation be enacted, Federal funding be provided for seed money and incentives to community-based treatment programs to get involved in drug abuse treatment programming for offenders. Right now there's not too many incentives. It's only when they begin to get hard-pressed by economic factors that allows them to say, well, maybe we'll reach into this population. I say create incentives to do that because that's the answer to a lot of the crime concerns which drives a lot of the drug legislation to start with.

I also recommend adding a requirement for evaluation research and for funding such evaluations to measure the implementation and outcome, so that any efforts undertaken by this legislation have a genuine result, that you can then have outside arbiters look at it, if it's an in-house evaluation, or you can put to the test by replicating it and other scientific means.

I think, in summary, if I were to have just a few words, I would say that we've got three purposes balanced in this system. We've got punishment by individual deterrence, and that is not something to be just tossed aside. The prison system which brings in somebody for robbery, burglary, or any other kind of crime, who also happens to be a drug user, there has to be a sense of punishment;

there has to be a sense on the part of the public that the system is responding to this. There has to be incapacitation, a direct preventive force used, and I think there is an obligation to retain people for prosocial change or rehabilitation during that process. It is an opportunity that you would otherwise not have.

Consequently, it is a responsibility, in my belief, just as mental health treatment is a responsibility for those who are mentally ill, for the system to deal with this population in a manner which will reduce the probability of their recidivism.

Thank you.

[The prepared statement of Mr. Lipton follows:]

PREPARED STATEMENT OF DOUGLAS S. LIPTON, PH.D, SENIOR RESEARCH FELLOW,  
NATIONAL DEVELOPMENT AND RESEARCH INSTITUTES, INC.

Mr. Chairman, members of the Committee, I am Dr. Douglas S. Lipton, Senior Research Fellow and Principal Investigator at NDRI, National Development and Research Institutes, Inc. of New York City. NDRI, a not-for-profit corporation, has since 1967 conducted drug abuse-related research and evaluation. Today, NDRI (formerly Narcotic and Drug Research Inc.) maintains five Research Institutes, a Training Institute, and an AIDS Outreach and Prevention Bureau. Its 200 staff persons are presently engaged in over forty projects relating to AIDS and IV drug use, substance use epidemiology, the relationship between crime and drugs, drug abuse treatment and prevention evaluation, drug abuse among special populations such as the mentally ill and the homeless, and drug abuse treatment in corrections. Our researchers are conducting studies in New York, New Jersey, Pennsylvania, California, and other states in the rest of the country, as well as with several nations.

We are the largest behavioral science research organization focusing on substance abuse in the United States. We are proud of the fact that many of our staff members are ex-addict and ex-offender professionals whose knowledge and insights about the street drug world have proven invaluable in our research efforts. Most of our funding is from research grants and contracts awarded by federal and state agencies. Some funding is from philanthropic organizations such as the Robert Wood Johnson Foundation.

By way of introducing myself: after I completed my doctoral work in 1963, I became Director of Research and Planning for the New York City Department of Corrections in 1964, directed research projects for the Social Restoration Research Center in New York 1965-1967, then joined the Governor Rockefeller's Special Committee on Criminal Offenders as Assistant Director. In the early 1970s as Assistant Director of the State Crime Control Council, the State Office of Crime Control Planning, and the State Division of Criminal Justice, I helped contribute to the crime control efforts

in the State. From 1972 to 1988, I served as Director of Research of NDRI as well as Deputy Director of the New York State Division of Substance Abuse Services in charge of drug abuse research for the State. Since 1988 I continued as Director of Research for NDRI until 1993 when I assumed my current position as Senior Research Fellow, and got back to doing hands-on research. I am proud to note that we [Dr. Harry Wexler and I] at NDRI directed the national effort to provide technical assistance on drug abuse treatment in corrections to the states. These efforts [called Project REFORM and Project RECOVERY] with funding from the Bureau of Justice Assistance of the U. S. Department of Justice and the ADAMHA Office of Treatment Improvement (now CSAT) developed comprehensive drug abuse treatment systems and programming in the correctional systems of 22 states from 1987-91. I have also evaluated drug abuse control and treatment programs around the world for the United Nations and have authored and co-authored many articles, chapters and books in this field.

Thank you for inviting me. It is a pleasure to appear before you to testify to what our research and experience show can be done to improve substance abuse treatment within the criminal justice system. Addiction treatment is a critical component of the Nation's war on drugs, and the incarceration of persons found guilty of various crimes who are also chronic substance abusers presents a propitious opportunity for treatment. It is propitious because these persons would be unlikely to seek treatment on their own, without treatment they are extremely likely to continue their drug use and criminality after release, and we now have cost-effective technologies to effectively treat them while in custody and thus alter their life styles.

I wish to you the genuine optimism I feel regarding our ability to effectively treat persons normally deemed by conventional wisdom to be "very high risk" (namely, chronic heroin and cocaine users with extensive predatory criminal histories). High rate addict-offenders such as these each commit 40 to 60



robberies a year, 70 to 100 burglaries a year , and more than 4000 drug transactions a year, yet we have reliable evidence that has substantiated more than a 25% reduction in recidivism after treatment—a reduction of that size yields a substantial and tangible improvement in our quality of life.

It is my intention to describe to you the success of a number of programs used in prison-based treatment of drug abusing offenders, to share with you my impressions of drug abuse treatment in the Federal Correctional program, and giving you my advice and recommendations regarding coerced treatment.

The field of corrections has not had notable rehabilitative successes, and it should be noted that I contributed to the commonly-held notion that "Nothing Works" that pervades the field today. This phrase emerged in an article purportedly summarizing a book I wrote with two colleagues (Robert Martinson and Judith Wilks) that was published in 1975 called *The Effectiveness of Correctional Treatment*. The book emerged at a time when the national media and the social climate were ripe for a shift away from the so-called "rehabilitative era."

As a researcher I am a professional skeptic—so when I see successful outcomes for correctional programming, and see it sustained over time and across projects with a group of offenders otherwise highly unlikely to succeed—it certainly captures my attention. [When I say success I am referring to reducing recidivism to a statistically significant degree. By recidivism I mean returning to prior forms of conduct as measured by parole violations, arrests, convictions, and reincarcerations.] Having looked at the research-based outcomes of hundreds of correctional treatment programs with a cautious lens, and having examined, with my colleague, Dr. Harry Wexler, this one, called Stay'n Out, for thirteen years, I want my words to convey to you our conviction that this program works.

I not only want to share with you the success of the Stay'n Out Project in reducing recidivism, but also of other programs such as Cornerstone in Oregon and the Key-Crest program in Delaware that have been as or more successful with drug abusing offenders. First, however, I believe it is necessary to take a look at the scope of the problem.

### **The Scope of The Problem**

I am sure that the Members of the Subcommittee are well aware that we have now surpassed the million mark for prisoners in the custody of federal and state correctional authorities, and that there are well over three million persons under community supervision. To be specific, 61% were on probation; 12% were on parole; 9% were in jail, and 17% were in prison—more than 4.3 million in total. This is the largest number ever held by criminal justice authorities. The prison population alone increased almost threefold between 1980 and 1995. Drugs played a major role in this increase—the increase is due in large part to the significant influx of drug abusers into the criminal justice system in the last dozen years (Mauer 1992). While the number of drug-involved individuals in the criminal justice system has always been appreciable, it is much greater now than in the past. This is due to a 15-year trend of massive growth in the criminal justice system which in turn is a response of the system to the public's most worrisome component—drug abuse-related crime. The public's concern has shifted the federal and state governments toward increased enforcement of laws related to drug possession, manufacture and distribution, as well as toward definitive and mandatory sentencing of drug offenders.

The increased incarcerated population results from more than drug-related crimes. The great majority of offenders appear to be involved with alcohol and other drugs regardless of charge. This is exemplified by the information from the Drug Use Forecasting (DUF) system which shows that for the last several years

between 60 and 70% of all arrestees in virtually all metropolitan areas test positive for drugs (US Dept. of Justice 1989). Between 1973 and 1988, the number of arrests made annually by police increased from 8 million to nearly 13 million, proportionately much faster than the population. Most of this police effort was concentrated on adults (during this same time period juvenile arrests declined 13%). [This shift is not explained by the demographic changes in age.] These adult arrests have increased disproportionately for drug-related crimes (BJS 1992b). Also it should be noted, that in this same period, the consequences of arrest have changed (as a result of mandatory sentencing) toward much greater likelihood of spending time in custody and subsequent community supervision—the average daily jail census nearly doubled, the prison census more than tripled, and periods of imprisonment combined with parole extend much longer (Anglin et al. 1992).

Although estimates vary, state correctional administrators generally report that 70-80% of inmates need drug treatment (Frohling 1989). Likewise, county jail data show high rates—about 40-45% of jail inmates report a need for drug treatment, and around 30% report needing treatment for their drinking. In local jails, the proportion of inmates charged with drug offenses increased from 9% to 23% from 1983 to 1989, with drug offenders accounting for 40% of the increase in the jail population during this period (BJS 1991).

Although 21% of state prison inmates were sentenced for a drug crime, close to 80% had used drugs, and over 60% had used drugs regularly. About one in three reported using drugs at the time of their offense.

Marijuana was the drug most used—more than half reported using marijuana on a regular basis. Half of all inmates had used cocaine in some form. Thirty-two percent had used cocaine or crack on a regular basis. About a third of the crack users were in prison for a violent offense, slightly less than a third for a property

offense, and about a third for a drug offense. Inmates who had used crack in the month before their offense were less likely to be in prison for a violent offense than those who had used other drugs or no drug. The percentage of crack users indicating that they had committed their offense to get money for drugs (55%) was almost three times the percentage of users of drugs other than cocaine or crack (20%) (BJS 1993). Heroin use was reported by one out of four, and about one out of every seven inmates used heroin regularly.

The cost of incarcerating the 1.1 million Americans behind Federal, state and county bars is \$20.3 billion (Mauer 1992). In 1980, about 1 of every 15 court-committed admissions to state prison was an offender convicted of a drug offense. In contrast, by 1990 drug offenses accounted for about 1 in 3 new commitments to state prisons. In the decade from 1980 to 1990, the number of drug offenders entering state prisons increased almost 12-fold (BJS 1992). During this past decade, state prisoners served an average of 14 months for drug trafficking and 12 months for possession—typically a little over a third of their sentenced time. In contrast, Federal drug offenders served over 38 months (59% of their sentences). In 1987, Federal parole guidelines over release of drug offenders were amended requiring such offenders to serve longer portions of their sentences. Many states have made similar changes (BJS 1990b).

The relationship between drugs and crime is indisputable after a decade of research documenting how much active addiction accelerates the rate at which individuals commit crimes. Ball et al., and Johnson et al. as well as others have shown that the rate of predatory crime rises between 4 and 8 times during periods of active addiction. The increasing rate of cocaine and crack usage and its effects on criminal behavior are well documented. The cost of the drug-related crime problem is now staggering. The National Institute on Drug Abuse (NIDA) estimates the cost at over \$60 billion a year.

All but eight states are under some kind of court order or consent decree to relieve prison crowding. Much of this prison crowding pressure is directly due to the righteous public outrage regarding drug-related crime and the resultant tougher sentencing practices that have been enacted for repeat offenders and criminals committing drug-related crimes, as well as just the dramatic increase in arrests directly related to crime increases generally. Drug-using offenders are a substantial proportion of the pool of persons now flooding the prisons and jails, and this trend of the nineteen eighties appears likely to continue undiminished as we move into the middle of the 1990s especially the Federal Crime Bill's recent passage.

Furthermore, the repeater rate of drug offenders is quite high. Up to two-thirds of inmates in some states (e.g., Oregon and Texas) are drug-involved former probationers and parolees. Although data vary across studies, it would appear that drug-using felons are also a primary source of failure on parole. That is, they constitute a disproportionate share of the repeat offenders. Sixty to 75 percent of untreated parolees with histories of heroin and/or cocaine use are reported to return to heroin and/or cocaine use within three months after release, and become reinvolved in criminal activity (Wexler 1988). The "revolving door" analogy epitomizes the situation with hard drug-using offenders. Since a great proportion of American drug users are processed through some part of the criminal justice system during their drug using careers, it makes a great deal of sense to consider that system as a location for treatment. Most inmates have not been treated in the community and state, when asked, that they have no particular interest in entering treatment. Thus, the criminal justice system is a major opportunity to bring to bear the state-of-the-art in drug abuse treatment for this otherwise elusive and recidivistic population.

Overall, then, the U. S. prison population has grown almost sixty percent over the past ten years largely fueled by the major influx of drug-using offenders. These offenders, largely recidivists, are responsible for a relatively large amount of crime, and among them, the most predatory, the heroin-using "violent predators", when compared with non-drug using offenders committed: 15 times as many robberies, 20 times as many burglaries, and 10 times as many thefts (Chaiken). Active drug use not only accelerates the users' crime rate, but also the crime quality is at least as violent, or more so, than that of non-drug using counterparts. It is interesting to note in this connection that the times in the last two decades that the homicide rate in the United States has peaked corresponds to the cocaine and crack wars for control of drug distribution (Goldstein 1991).

### Treatment

Very few inmates, despite the demonstrated need for treatment services, actually receive treatment for their addiction, either before, during or after their incarceration. Drug Use Forecasting data show that, on the average, only four percent of arrestees are receiving treatment at the time of arrest, and about 22 percent of arrestees have ever received treatment services of any kind. In a recent street survey of active heroin and cocaine users that we conducted in New York City (as part of Pathways into Treatment project), 70% had never been in treatment and had no current intention of ever entering (although some had experienced detoxification). In 1979, the National Institute on Drug Abuse conducted a comprehensive survey of drug abuse treatment programs in prisons (NIDA, 1981). The survey identified 160 prison treatment programs serving about 10,000 inmates (four percent of the prison population). Chaiken estimated that in 1987, 11.1 percent of the inmates in the 50 states were in drug treatment programs (Chaiken 1989). Although this represents a sizable increase (from

10,500 inmates in 1979 to 51,500 inmates in 1987), the vast majority of inmates with substance abuse problems still do not receive treatment while in prison.

While there is still no precise figure about the percentage of offenders being treated for drug use, recent incomplete surveys of treatment for incarcerated drug abusers show: thirty-nine states using preliminary assessment procedures with newly sentenced inmates; forty-four states allowing Narcotics Anonymous, Cocaine Anonymous or Alcoholics Anonymous self-help group meetings once or twice a week; forty-four states having some form of short-term (35 to 50 hours) drug education programming; thirty-one states having some form of individual counseling available for drug users where a counselor or therapist meets with an individual inmate occasionally during the week; thirty-six states having group counseling in which small groups of inmates meet once or twice weekly with a therapist; and, 30 states having some type of intensive residential program, often based on the therapeutic community (TC) model. Most optimistically, less than 20 percent of identified drug using offenders are believed to be served by these programs (Frohling, 1989).

### **Treatment Works**

Prior to 1980, relatively few outcome research studies of TCs in prison settings had been conducted. Recently published findings regarding the Stay'n Out Program by Wexler, Lipton and Falkin and colleagues (1989, 1990) and the Cornerstone Program by Gary Field (Field 1984, 1989) and the Key-Crest program in Delaware by James Inciardi and colleagues (1995) substantiate the significant accomplishments of correctional-based TCs with incarcerated drug abusing felons.

**The Stay'n Out Program.** The Stay'n Out program is a therapeutic community for the treatment of incarcerated drug offenders which has been

identified as a national model. Stay'n Out began as a joint effort by the New York State Division of Substance Abuse Services, which funded the program during its first years, New York Therapeutic Communities, which operates it, and the New York State Department of Correctional Services which currently funds it. It has two sites: a program for male offenders at the New York State Arthur Kill Correctional Facility on Staten Island established in 1977, and one for females, opened in 1978 at the Bayview Correctional Facility in Manhattan. At its maximum, there were four treatment units at the Arthur Kill Correctional Facility, with about 35 beds per unit (a total capacity of 143 beds), and one female treatment unit at the Bayview Correctional Facility, with 40 beds. Also, Stay'n Out opened Serendipity House four years ago—a halfway house in Brooklyn for the reentry phase of Stay'n Out graduates.

In 1984, the National Institute on Drug Abuse provided a grant to NDRI to evaluate Stay'n Out and compare it to other prison drug abuse treatment programs. The evaluation was designed to test the proposition that effective treatment of substance abusers is possible within prison. A large-scale, quantitative analysis was conducted relating several measures of treatment outcome (e.g., rearrest, reincarceration) to both client characteristics and program attributes (time in program and termination status). The study included males and females as well as treatment and no-treatment comparison groups. Statistical analyses were performed to test whether the Stay'n Out therapeutic community is more effective at reducing recidivism than no treatment and alternative prison-based drug treatment modalities, and whether increases in time-in-program would be related to reductions in recidivism, among other questions. Both were affirmed, with the main finding being that maximum reductions in recidivism occur for those inmates spending nine to twelve months in program (Wexler, Falkin and Lipton, 1990).



### Stay'n Out

Since the program began, nearly 1,500 men and over 500 women were admitted to treatment. The aim of the program is to treat felony offenders for their drug abuse and related problems so that they are less likely to recidivate after leaving prison. Inmates selected for the programs are recruited at state correctional facilities. The criteria for admission to the program are: official history of drug abuse (or indication of involvement in the drug culture); at least 18 years of age; evidence of positive institutional participation; no history of extensive violence, arson, sex crimes, or mental illness; that inmates be no more than 12 months nor less than six months away from their first parole hearing.

On average, males in the Stay'n Out program have previously been convicted four times and have been incarcerated for four years (prior to admission into Stay'n Out). Most of the offenders are in prison for robbery (43%), drug sales (18%), or burglary (18%). Drug abusers in the Stay'n Out program have been heavily involved in drug use since sixteen and a half on the average. Seventy-three percent abused opiates; 77 percent have abused cocaine (and other stimulants). On the average, two previous attempts at changing their lifestyle have failed (about 18 months of treatment combined).

The Stay'n Out programs at Arthur Kill and Bayview are therapeutic communities modified to fit into a correctional institution. (See Wexler and Williams [1986] for a full description of the program). During the early phase of treatment, the major clinical thrust involves observation and assessment of client needs and problem areas. Orientation to the prison therapeutic community procedures occurs through individual counseling, encounter sessions, and seminars. At the outset clients are given low-level jobs and granted little status. During the latter phases of the recovery process, residents are given opportunities to earn higher level positions and increased status through sincere involvement in the program and hard work. Encounter groups and counseling sessions are more in-depth, and focus on the areas of self-discipline, self-worth, self-awareness, respect for authority, and acceptance of guidance for problem areas. Seminars take on a more intellectual nature. Debate is encouraged to enhance self-expression and to increase self-confidence.

Stay'n Out clients are housed in units isolated from the general prison population, however, they do attend morning activities with other prisoners, and eat in a common dining room. Most program staff are ex-addicts who are graduates of community-based therapeutic communities as well as ex-offenders. Employed by New York Therapeutic Communities, Inc.(NYTC), they act as role models demonstrating that persons just like themselves can be successfully rehabilitated. NYTC is contracted with annually by the New York State Department of Correctional Services to provide the entire Stay'n Out program at both facilities. All but one of the units are staffed by a unit director and three counselors; one unit at Arthur Kill has only two counselors.

Upon release, participants are encouraged to seek further substance abuse treatment at cooperating community-based therapeutic communities (TCs) [and now at Serendipity House, Stay'n Out's own halfway house in Brooklyn, which did not exist until after our evaluation study was completed.] About half the program graduates actually continue in residential programs. Extensive involvement with a network of such community TCs is central to the program's operation. Staff and upper residents of community TCs visit Stay'n Out on a regular basis to recruit resident inmates for their programs. These visitors provide inspiration since they are ex-addicts and ex-felon role models who are leading productive lives.

### **The Stay'n Out Evaluation**

The evaluation research design compared a male TC treatment group (N=435) and a female TC group (N=247) to no-treatment control groups and alternative treatment groups. The male treatment group was compared to the no-treatment control group (N=159), which consisted of inmates who were on a waiting list for the program. They met all the criteria for admission except the parole time eligibility criterion and, therefore, completed their prison term without treatment. The male treatment group was also compared to a milieu treatment group (N=576), which offered a less intensive treatment than the TC (i.e., time was less structured; there was no hierarchy of jobs or social roles; counselors were not ex-addicts or ex-offenders but trained correctional officers; good conduct in the program was not rewarded with greater responsibility; and interaction with

community TCs was less extensive). In addition, the male treatment group was compared to a counseling group (N=261), which only received individual and group counseling once a week. The female treatment group was compared to a no-treatment control group (N=38) and a counseling treatment group (N=113); these groups were similar to their male counterparts (i.e., the control group met the basic criteria for admission but did not receive treatment, and the alternative treatment group received only counseling services once a week).

In general, the background characteristics of the samples were comparable, and multivariate statistical analyses were performed to control for the possible confounding effects of any differences on treatment outcomes. The groups were compared according to several recidivism measures: the percentage arrested, the mean number of months until arrest, the percentage positively discharged from parole, and the percentage not reincarcerated. The sampling time-frame was based on inmates released from prison between 1977 and 1984; the follow-up period (which ended in 1986), therefore, ranged from 3 to 9 years, depending on the year prisoners were released (almost all had at least three years, many had six years of follow up).

Statistical analyses were performed to compare the effectiveness of TC treatment with alternative interventions and no treatment and to assess the relationship between treatment outcomes and time in treatment. The across group comparisons yielded mixed results (i.e., when compared to the other groups, the TC groups had significantly lower arrest rates but differences in other outcome variables were not significant); however, the most powerful finding was that there was a consistent and significant correlation between treatment outcomes and time in program. The Stay'n Out evaluation research like other TC evaluation research consistently found statistically significant and salient effects between time in program and treatment outcomes. Generally speaking, the failure to look at time in treatment is almost always bound to mask important findings and could yield spurious no-difference outcomes.

Male and female Stay'n Out clients do better on parole if they remain in the program for 9 to 12 months rather than terminating earlier (or later). Furthermore, similar lengths of time spent in the comparison modalities do not produce a positive effect. This pattern was found to be

consistent for the other outcome variables as well, leading to the **firm conclusion that Stay'n Out is more effective than no treatment and alternative treatments, especially so when clients remain in treatment for an optimal period—9 to 12 months.**

When clients who completed the program in 9 to 12 months were compared with clients who left within three months, differences between the percentages positively discharged from parole for the two treatment periods were significant. Among the males who terminated in less than three months, the percent with favorable outcomes was only 49.2 percent, whereas the counterpart rate for the males who stayed in the program for 9 to 12 months was 77.3 percent. Similar findings were obtained for females, although the percentages with favorable outcomes were generally higher than for their male counterparts (79% favorable outcome for females in treatment less than three months vs. 92% favorable outcome for the 9 to 12 month group).

For those who failed (i.e., those rearrested or reincarcerated), more time in TC treatment was also related to positive treatment outcomes. When the mean time until arrest was compared for the two termination periods, it was found that clients who received treatment for shorter periods were arrested much sooner than those who stayed in the program for 9 to 12 months. Furthermore, the percent of Stay'n Out male clients who were not reincarcerated after 9 to 12 months of treatment was considerably higher (72% within three years after release from prison) than for males who resigned or were dismissed earlier (60% within three years). Indeed, a statistical [logistic regression] analysis showed that the odds of not being reincarcerated were nearly three times greater for clients who remained in treatment for 9 to 12 months than for clients who spent less than nine months in treatment adequately controlling for the effects of motivation, deterrence, and treatment.

Clients who received 9 to 12 months of treatment were not only less likely to recidivate than clients who spent less time in treatment, but they also did better than clients who remained in treatment over one year. This finding was consistent for most of the outcome measures tested (time until arrest, positive parole discharge, reincarceration). A multiple regression analysis confirmed a statistically significant decline in time until arrest for clients who remained in treatment for more than 12 months. *It should be*

*noted, however, that the clients in this group are still significantly less likely to recidivate than those who terminate from the treatment in less than nine months. We are not certain why this increased risk of failure occurs for those who spend more than 12 months in program, but we speculate it is due to two factors: the optimum effectiveness for the in-prison TC is 9 to 12 months; and there is anger and depression generated by not being released on parole after graduating at the end of one year in the program. Having to spend additional time incarcerated before being reconsidered (in the light of the expectation to be paroled) has negative effects on progress toward rehabilitation. Thus, the robust central conclusion of the Stay'n Out research is that hard-core drug abusers who remain in the prison-based therapeutic community longer are more likely to succeed than those who leave earlier, and that 9 to 12 months appears to be the optimal duration for the treatment.*

**The Cornerstone Program.** The Cornerstone program is a well respected treatment program for alcohol and drug dependent offenders that began in 1976 and is situated on the grounds of the Oregon State Hospital in Salem, Oregon. It consists of a 32-bed residential unit and a six-month aftercare program. Cornerstone is jointly administered by the Oregon Divisions of Mental Health and Corrections. Inmates are referred to the program by prison counselors. Admission criteria require that candidates have a history of substance abuse, do not have a history of psychosis or sex offenses, are at least six months but not more than twelve months from their parole, qualify for minimum security, and plan to remain in the state after release. In 1984, Cornerstone clients had an average of about seven felony convictions, had served over seven years in prison, and all but five percent of the clients had histories of polydrug abuse.

Like Stay'n Out, Cornerstone is modeled on the therapeutic community concept. The conditions that prevail at Cornerstone regarding rules, group participation, earning privileges and so forth are almost the same as in the New York program. The major difference between the two programs is that Cornerstone had, at the time of its evaluation, a six-month aftercare phase in which graduates worked and lived in the community, and few of the staff were recovering persons—i.e., role models.

Two evaluation studies of the Cornerstone program assessed several treatment outcomes, including recidivism (Field 1984, 1989). The findings of both studies are summarized here because they demonstrate the effectiveness of the program over time. The 1984 study evaluated all clients who graduated between 1976 and 1979 against three comparison groups: (1) clients who dropped out in less than one month during the same time-frame; (2) all Oregon parolees (from 1974 to 1977) who had a history of substance abuse; and, (3) a sample of Michigan parolees. There were no statistical differences between the demographic characteristics of the program graduates (N=144) and the dropouts (N=27). The group of Oregon parolees (N=179) had significantly less severe histories of substance abuse and crime than the program graduates. The sample of Michigan offenders (N=217) was based on a population similar in background to the Cornerstone groups.

A three-year follow-up study compared the groups according to two outcome measures: the percent not returned to prison and the percent not convicted of any crime. *The program graduates had a significantly higher success rate for both outcome measures than each of the other groups. Seventy-one percent of the program graduates were not reincarcerated three years after release; only 26 percent of the dropouts avoided reincarceration.* Similarly, while slightly more than half the program graduates were not convicted of any crimes (including minor offenses), less than 15 percent of the dropouts were not convicted of any crimes. As Field points out, the factors that cause residents to drop out may also influence recidivism; however, the favorable comparison with the other two groups supports the hypothesis that treatment in the Cornerstone program is associated with reduced recidivism. Indeed, statistical tests of both outcome measures showed that Cornerstone graduates had significantly better outcomes ( $p < .01$ ) than the Oregon parole sample (63 percent of the parolees were not reincarcerated and only 36 percent were not convicted of any crimes). These univariate statistical differences tend to understate the effect of the treatment because the program graduates had significantly more severe criminal and substance abuse histories.

Field's 1989 study produced similar results, using a different research design. A group of program graduates (N=43) with an average stay of eleven months in treatment was compared with three groups of clients who

did not graduate: (1) clients who spent over 6 months in the program (N=43), (2) clients who spent between 2 and 6 months in treatment (N=58), and (3) clients who were in treatment for less than 2 months (N=65). The measures of recidivism that were assessed in the three-year follow-up include: the percent of each group without arrest; without conviction; and, without reincarceration (which included jail terms greater than six months as well as prison sentences).

The results for the program graduates in this sample were quite similar to the findings in the earlier evaluation. Slightly more than half the graduates were not convicted and about three-quarters were not reincarcerated; in addition, 37 percent were not arrested. These results compared quite favorably to the three groups that did not graduate. For example, 21 percent of the non-graduates who were in treatment for over six months were not arrested, 28 percent of them were not convicted, and 37 percent were not reincarcerated. The findings for the other drop-outs are even more startling. Only eight percent of the clients who dropped out in less than two months were not arrested during the three year follow-up, only 11 percent were not convicted, and only 15 percent were not reincarcerated. These findings are consistent with the findings on the Stay'n Out program, which showed that increased time in program is associated with more positive treatment outcomes.

In addition to comparing the percent in each group that did not recidivate, Field assessed the effect of the treatment on rates of recidivism, that is, the average number of times clients in each group were arrested, convicted, and incarcerated. (These measures imply an expected probability of the number of times offenders will recidivate depending on the amount of time they spend in treatment.) The three-year post-treatment period was compared to two different three-year intervals prior to the prison term that involved treatment in the Cornerstone program. These intervals were the 36 months "at risk" prior to the Cornerstone incarceration and the prior 37 to 73 months "at risk". (The "at risk" intervals represent time in the community; they exclude time spent incarcerated.) Because some subjects were too young to be "at risk" for six years before the Cornerstone incarceration, only about 75 percent of the subjects in each sample were included in this analysis.

The results of the analysis were consistently lower for the program graduates in terms of the percent of each group that did not recidivate (whether measured by arrest rate, conviction rate, or incarceration rate). Furthermore, as the length of time in treatment increased, recidivism rates declined. Perhaps the most interesting findings pertain to the comparisons between the pre-treatment and post-treatment intervals. *Whereas the recidivism rates during both pre-treatment intervals were about the same for each of the groups, recidivism rates during the post-treatment period were considerably lower among the program graduates, and the amount of decline in recidivism rates between the pre-treatment and post-treatment periods was greatest for the program graduates.*

**The Key-Crest Program.** The Key-Crest program is a three stage model program operating within the Delaware Correctional system. Only the first two stages have been operationalized. It is built around two therapeutic communities, the KEY, a prison-based TC for men; and CREST, a residential work release center for both men and women. The concept of the Key, the primary stage of treatment, is modeled on the Stay'n Out program, a twelve-month intensive residential TC occurring within the institution. Here there is time for comprehensive treatment, where time and isolation are resources for working on problems, and where the competing demands of the street, work, friends and family are absent. This program differs from the prior two described above because of its secondary stage of treatment—a "transitional TC", a therapeutic community work release program. In this stage inmates who are near their release date are allowed to work for pay in the free community while spending their non-working time in the "family setting" similar to a traditional TC. The third stage (aftercare) is for the released inmates, now parolees, who have completed the first two stages, and are living in the free community under parole or other supervision. Intervention at this stage involves out-patient group and individual counseling, and the opportunity to return to the work release TC for refresher/reinforcement sessions, to attend weekly groups, and to spend once a month at the Work Release TC.

Data from drug-involved offenders receiving the first two stages (prison-based TC followed by work release TC) are surprisingly good. The research evaluation design contrasts the Key alone, Crest alone, the two



combined—Key-Crest, against no treatment other than HIV prevention education. The subjects are 81% male, 82% with prior drug treatment, 72% Afro-American, mean age 29.6, first arrest at 17 years, and 2 previous incarcerations. Results after 6 months by treatment groups, controlling for other factors (e.g., days in treatment, follow-up time, previous times incarcerated), show highly positive outcomes in terms of both drug-free and arrest-free status. **The percents drug free were Comparison, 38%; Key, 54%; Crest, 84%; and Key-Crest, 94%. The percents arrest free were Comparison, 62%; Key, 82%; Crest, 85%, Key-Crest, 97%.** (Martin, Butzin & Inciardi 1993). Inciardi 1995). **At 18 months the percents drug free were 17%, 34%, 46% and 75% respectively, and the percents arrest free were 36%, 45% 60% and 70% respectively.**

These studies, of the Stay'n Out program, the Cornerstone program, and the Key-Crest program are the first large-scale research evaluations to provide solid evidence that prison-based therapeutic community treatment can produce significant reductions in recidivism rates among chronic drug abusing felons, and to show consistency of such results over time. This is not to say that prison-based therapeutic communities have not been successful before, but that formal research evaluations have not been undertaken before these. [In fact, TCs have been used since the early fifties in many Federal and state prisons, and most lasted about 7 to 9 years usually until budget priorities changed.] It is worthwhile noting that the success of this type of holistic treatment is probably due to the fact that it deals with many of the inmates' social and psychological impediments to returning to acceptable social functioning. It deals with the myriad problems associated with the lifestyle of addiction as well as the drug use—and is therefore more likely to be successful in the long run than treatment programs that focus mainly on drug abuse.

The cost effectiveness of the treatment supports its implementation even more graphically. Programs like Stay'n Out cost about \$3000 to \$4000 more than the

The cost effectiveness of the treatment supports its implementation even more graphically. Programs like Stay'n Out cost about \$3000 to \$4000 more than the standard correctional cost per inmate per year. [Programs like Cornerstone with more professional staff and one-fourth the caseload per staff member cost a little over twice as much for the same time period.] The savings produced in crime-related and drug use-associated costs, however, pay for the cost of the treatment in about two to three years. It is an inescapable conclusion that treatment lowers crime and health costs as well as associated social and criminal justice costs. Moreover, the higher the investment in rehabilitating the most severe offender-addicts, the greater the probable impact. The most serious chronic heroin and cocaine users (about 3 to 10% of all offenders, depending on jurisdiction) are each responsible for a high volume of predatory crime. (Gropper, 1985 based upon the work of Johnson et al., 1985; Ball et al., 1983; and Inciardi, 1979). Any substantial reduction in such criminality among this group immediately has an impact on our quality of life. Without intervention this group will return to crime and drug use nine times out of ten after release, and most will be back in custody within 3 years. With appropriate intervention applied for a sufficient duration, more than three out of four will succeed, i.e., reenter the community and subsequently lead a socially acceptable life. This highly predatory group is amenable to long-term (9-12 month) therapeutic community treatment while incarcerated [or in a combined program begun in the institution and continued in the community], and is unlikely to benefit significantly from treatment lasting less than 6 months.

### **Community Care and Continuity of Treatment**

An important lesson learned from these and other programs that have succeeded with drug-abusing inmates is programs that begin within the prison's

wall must continue into the community after the inmates release, and optimally they should continue for the length of time that the criminal justice system has custody. Changing a drug abuser's lifestyle is a difficult and time-consuming process. The experience of reentry after treatment for an offender is even more difficult because of all the temptations and triggers to relapse (conditioned cues) that are encountered upon returning to where one used drugs. It is essential therefore to strengthen paroling authorities with program referral and direct service options for former drug abusers being released on parole. Self-help groups for recovering persons generally appears to be an important element in forestalling relapse. Participation in self-help groups such as Narcotics Anonymous and Cocaine Anonymous appears to be a positive, if not essential, element.

Another point I wish to emphasize, Mr. Chairman and Members of the Committee, is the need to include a wide variety of services to meet the needs of the imprisoned population. These persons, largely from minority groups and from well-below-average income backgrounds, lack social and vocational skills, lack literacy and numeracy, and suffer from a variety of psychological and psychiatric ills. They function poorly without remediation of these problems, but respond well to "habilitation" programs that provide these components. Offenders' addictions cannot be treated in isolation from their medical, psychological, social and practical deficits. Programs that are initiated must deal with inadequate communication skills, inadequate understanding of human relationships and responsibility, insufficient maturity level, and inadequate job skills among other things. Habilitation programs such as Stay'n Out, Cornerstone and Key-Crest deal very well with many of these deficiencies, but still lack the breadth of service programming necessary to help many persons. The men who failed in Stay'n Out, for instance, in most cases failed for vocationally-related reasons. The outstanding

success of the Key-Crest program may well be due to the transitioning into employment through work release. The success of programs like Stay'n Out, however, can be enhanced and sustained with a thoughtfully coordinated continuum of therapeutic services and this is strongly warranted for criminal justice populations.

Good treatment is a scarce resource and it should be focused where the greatest likelihood exists for producing the kind of human change that will positively affect the quality of life. Hence, the desire to treat everyone who wants treatment may be a dissipation of resources, and should be guided by a focus on getting the "biggest bang for the buck." The focus, I believe, should not be on marijuana users, but on serious chronic heroin and cocaine users who are likely to be the most predatory offenders—that is, who cause the most crime. Changing their behavior will obviously result in the most visible and significant change. Ways must be found to have the therapeutic process continue long enough to be productive. Nonetheless, by concentrating on these offender-addicts, the effort will undoubtedly have a salutary effect on our quality of life while being cost effective—a salient factor to the public's view.

#### **The Correctional Drug Abuse Treatment Effectiveness Project**

It should be noted in this connection that I and my colleagues are currently conducting a study that I believe you should know about. We call it CDATE, which stands for Correctional Drug Abuse Treatment Effectiveness, but it is much more than the title implies. It is a comprehensive detailed review of the evaluation research on rehabilitation programs for offenders generally. We are giving special attention, however, to drug treatment offered to offenders in all levels of criminal justice custody. It is funded for three years by the National Institute on Drug Abuse—it began in 1994 and ends in 1996.

This research activity is assembling, annotating, and analyzing all studies conducted since 1968, i.e., since the studies reported by myself and my colleagues, in *The Effectiveness of Correctional Treatment: A Survey of Treatment Evaluation Studies* (1975). In this study we are a) seeking out all credible evaluation studies of treatment of offenders, drug abusing and non-drug abusing alike, b) examining and assembling them to inform policy and practice in the most meaningful way, and c) assessing the effectiveness of correctional treatment at the current state of the art.

Our specific aims include: 1) Developing a comprehensive information data base of correctional treatment evaluation studies from all countries completed between January 1, 1968 and December 31, 1994; 2) Categorizing and annotating systematically all studies; noting separately participation by and outcomes for offenders with drug abuse histories; 3) Critically evaluating their methodologies; 4) Assessing the impact of the various treatments on several outcome measures, particularly drug abuse and recidivism; 5) Describing the policy implications of the results for correctional treatment programming, training, staffing, program implementation, programmatic evaluation and future research; 6) Describing each modality of treatment for offenders in detail in terms of size, variety, clientele, goals, staff, setting, relative isolation, use of incentives, duration, frequency, intensity, priority, completeness of implementation, relationship to drug abuse, continuity of treatment, outcome, and many other factors; 7) Describing and analyzing each outcome criterion (e.g., relapse to drug use, recidivism) in terms of variety, relative precision, and utility for evaluations of correctional treatment for non-drug abusing offenders as well as drug abusers; 8) Performing a meta-analysis comparing the effect of each treatment on each of the outcome variables; and comparing effect sizes for different population subsets (e.g., gender, age and race groupings); and assessing the degree to which a variety of independent variables (e.g., treatment methods, program

characteristics, client characteristics, research methodologies) have effects on evaluation findings. 9) Disseminating the findings widely to practitioners, policy makers, and legislators on "what works" in correctional treatment for non-drug abusers as well as drug abusers. 10) Depositing the entire collection of articles, documents, etc. and annotations in a publicly accessible library. If funded, we will make available the entire data set on CD-ROM.

We are also compiling, translating and adding to our analysis the valuable contributions of the correctional evaluation research work of scientists in other countries over the last 25 years—chiefly from Great Britain, Canada, Australia, Netherlands, Germany, Norway and Sweden which will be incorporated into this compendium of the literature of correctional rehabilitation, and into the meta-analysis.

#### **The Use of Coercion to Get Persons into Treatment.**

A look at the scientific literature sheds some light on the question of whether clients coerced into community treatment or induced into entering prison-based treatment do as well as those who enter treatment voluntarily. Studies summarized well by Anglin and associates provide confirmation that legal coercion is effective in reducing substance abusing behavior among those who will not seek treatment voluntarily. According to studies by my colleagues and by McFarlain, and by Schnoll, legal pressure also increases admission rates into treatment programs and appears to promote better retention in treatment consequently improving the overall results for the program and for individual patients. Schnoll also found that clients admitted to community-based treatment after release from prison were most likely to complete the program. Longitudinal data from Sells and Simpson's Drug Abuse Reporting Program also show that coercion does not impair the effectiveness of treatment programs, i.e., clients entering treatment with some legal involvement performed as well as those who

entered voluntarily. In a study that examined the separate and combined impact of methadone maintenance treatment and legal intervention, the outcomes demonstrated overall that legal supervision was better than no treatment in improving the drug-related behavior of opiate addicts, methadone was much better than legal supervision, and the combination of the two was at least as good as methadone maintenance alone, and was better in regard to abstinence from narcotics use.

### **The Federal Bureau of Prisons**

My understanding is that the Federal Bureau of Prisons is now providing drug abusers treatment while incarcerated in Federal prisons. In 1990, Mr. Quinlan reported, somewhat embarrassedly that only 3800 persons were enrolled in drug education and/or treatment programs within the Bureau, despite the fact that almost fifty percent of the population had a moderate to severe drug abuse problem prior to incarceration. He announced then a series of steps to ameliorate the situation. The steps he announced consisted mainly of establishing drug abuse education and counseling programs in every institution (of about 40 hours in length); five comprehensive residential drug abuse treatment (basically 500 hours over nine months followed by a reentry phase); and three pilot intensive drug abuse treatment programs (1000 hours over 12 months with twice the staffing ratio) with strong evaluation components. I do not know to what level Mr. Quinlan and his successor achieved in reaching these excellent programmatic goals. I do understand, however, that some obstacles were encountered over the last four years.

### **Recommendations**

- I recommend focusing limited treatment resources on chronic heroin and cocaine abusers because that is where the greatest impact will occur.
- I recommend implementing models of prison and jail-based treatment that have demonstrated success with hard-core offender addicts.

- I recommend inviting community-based programs to develop programs for the treatment of substance abusing inmates that begin in the correctional facilities AND continue in the community.

- I recommend that Federal legislation be enacted and Federal funding be provided for seed money and incentives to community-based treatment programs to implement such substance abuse treatment programming.

- I recommend adding a requirement for evaluation research and for funding such evaluations to measure the implementation and outcome of the efforts undertaken under this legislation.

### Conclusion

Offenders, whether incarcerated or under field supervision, adult or juvenile, male or female, frequently have daunting needs, especially those with substance abuse dependency. The diagnostic and classification issues require time and effort, and the delivery of quality treatment is costly and time consuming. Yet, the period of custody is an opportunity to discover the problems that are highly conducive to recidivism, and to bring to bear treatment that in all likelihood would not be sought voluntarily otherwise. The results of successful treatment are lowered criminal and social costs, reduced transmission of disease (e.g., HIV and hepatitis), and reduced crime in society. The application of even short-term intensive treatment across the range of drug use-related needs, however, requires a level of staff training and dedication rarely found among correctional and field supervision officers and rehabilitation workers. This is not to say that the commitment to support and bring about prosocial change is absent—rather the funding is too low to initiate and sustain effective holistic programming, and to recruit and train motivated staff. This, in turn, is a consequence of a combination of funding competition, inertia, legislative (or congressional) and executive indifference, and public ignorance. These factors



are, unfortunately, the legacy of racial and ethnic discrimination coupled with the fear of HIV/AIDS and predatory antisocial behavior, and righteous anger as well—an inauspicious formula for public support. Moreover, the burden of change is complicated by the factor that most of the problems that need to be addressed holistically are under the jurisdiction of different and often competing governmental structures—organizations that rarely communicate with each other, and even more infrequently, join in a common enterprise.

There are persons in senior policy making positions as well as academia who could not agree that rehabilitation is or should be one of the key purposes of the correctional system. If it comes down to a matter of opinion whether state, Federal and county corrections have a responsibility to undertake correctional rehabilitation, I will firmly urge it. The empirical evidence at the current time appears to support its utility. I assert that the federal government, the states and America's largest cities have a responsibility to encourage and underwrite rehabilitation for addict-offenders, and a significant opportunity to do so. Three balanced purposes can and should be effectively and simultaneously served: (1) punishment (individual deterrence); (2) direct preventive force (incapacitation); and (3) retention for prosocial change (rehabilitation).

I Thank you for the opportunity to share these insights and thoughts with you.

References for all these remarks may be obtained by request.

Mr. MCCOLLUM. Well, thank you, Dr. Lipton.

While we're with you, I'd like to know if you can tell us how successful drug treatment programs are where prisoners are required to participate as opposed to those who do it voluntarily? Do you have any—

Mr. LIPTON. They're actually more effective.

Mr. MCCOLLUM. Where they're required?

Mr. LIPTON. Right. That doesn't mean that you take everybody who is in the institution and require it uniformly, but where you provide additional leverage of the legal system, you hold them in treatment longer, and longer treatment is more effective than shorter treatment.

Mr. MCCOLLUM. What about the law change that Mr. Heineman mentioned earlier—you may have been here listening to it—that we did a couple of years ago in the Federal system which allows a year out earlier if you are not a violent criminal and you go through drug treatment voluntarily—

Mr. LIPTON. I have some strong feelings about the use of incentives. I think positive incentives, as well as negative incentives, should be used to induce people into treatment. It's not necessary, however, to reduce sentences by a whole year. I think that it is just as sufficient—and this is my opinion, not evidence, but it's just as sufficient to even get 3 months off—

Mr. MCCOLLUM. Good point.

Mr. LIPTON [continuing]. And to also come away with a reward that's tied to the level of success achieved. So that they know the longer they're out, the shorter the supervision. The better their behavior, the shorter the community supervision, that kind of thing.

Mr. MCCOLLUM. Thank you.

Dr. Shapiro, do your costs per capita include security and transportation in the figures you gave us? Do they include those costs? Do you know—

Dr. SHAPIRO. The answer is sometimes. For example, they certainly include any ambulance services. They certainly include costs like that. They don't include the guards in our direct costs, but we've shown that we reduce utilization of outside services, so we reduce guards' cost, and that's an additional saving.

But I must admit I say this with a little trepidation because we do want to work with the Bureau of Prisons. I also am unaware of any other prison system in America, or jail system in America, where they classify their correctional officers' time segregated as a health care cost. The health care budget for the Federal Bureau of Prisons clearly is about \$3,200 an inmate, and I just can't believe that they actually include the costs of the guards attending health care. Especially given the way guards move around in every system in America, I can't believe that they do their accounting to include real guard costs.

But even if you take those numbers, Mr. Chairman, of \$3,200—and Dr. Hawk said it becomes \$2,500 if you take those costs out—in the State of Maryland, right around the corner, we're providing health care, including transportation, including no catastrophic limit—so we're up to whatever it costs in Maryland—for under \$1,500 an inmate, including hospitalization at the University of Maryland, including mental health services. So we're, either com-

paring \$1,500 versus \$2,500 or \$1,500 versus \$3,200, we're doing it well.

We'd love to take you or anyone there to see our system. The quality is good because we're a publicly-traded company, and if we make mistakes, we're held accountable to our shareholders and we're held accountable for any malpractice. So we don't want to make mistakes. So we do our job. And, again, Dr. Hawk said we use uncertified and unlicensed personnel, which is simply not true.

Mr. MCCOLLUM. Understood.

Dr. SHAPIRO. We will only use licensed personnel. We don't use foreign medical graduates, as the Federal Bureau of Prisons does, unless they're licensed, and they use them as physicians' assistants and we won't. So the reality that I think is an honest apples to apples comparison, is how the BOP classifies their real security costs under their system.

Mr. MCCOLLUM. Well, one of the reasons we're asking—why I asked you the question—is so we can try to make some comparison or get more data.

Mr. Brys, speaking of apples to apples, oranges to oranges, or whatever, that was one of the comments you made, and when Dr. Hawk testified, she said that the prison being built in Houston was high security; it was an entirely different type of prison, and you indicated that there would be an apples-and-oranges-type of response.

She also indicated that the double-bunking was going to have to continue and that the 80-square-foot-per-inmate was really not high; it was actually low, if you counted it at 40 per person.

Do you have a response to either of those comments that she made?

Mr. BRYs. Yes. I would enjoy responding. A couple of points of clarification: the Director said that, in particular, the Houston facility they used as a comparison was a very minimum or low-risk facility, based upon input to her from Andy Collins, the director of the Texas prison system. It should be noted that prior to them moving into that facility, Andy Collins decided to change the security designation of the facility from low/medium risk to a transfer facility. He asked our company to harden the facility to house all types of inmates. So today, as we speak, there are 600 very high-risk people in that facility. So it is functioning. They haven't had people crawling out the windows, and it is functioning very well—

Mr. MCCOLLUM. What you're saying is you don't think you have to build a prison that is as different or more expensive for a high-risk prisoner?

Mr. BRYs. I think the point I'm bringing up is that even our low-risk facility has a sufficient deterrent so that it can function as a high-risk facility. Facilities are relative, as far as what they can do and what they can't do. Our low-risk facility that was cited is, in fact, holding high-risk offenders at this point in time.

The other point she brought up was that in Dallas this was not a complete facility. It didn't have a kitchen. It didn't have a laundry. It didn't have medical support. Well, the Dallas facility is a total facility. It has a full medical, full laundry, full support services in the facility. It's 240,000 square feet of building. It has hous-

ing for 2,000 inmates. It has support services for those 2,000 inmates. It has support services for all the guards that will work in that building. It is a total, complete, self-contained building, very similar in size to what the Bureau is now highlighting to be built in Houston for one of their metropolitan detention centers.

I'm citing that to just say that it is a fairly comparable apples-to-apples comparison, the point also being that the Director highlighted 40 square feet per inmate being a new or the latest requirement. I couldn't help but think that, if the Houston facility they're proposing for \$54 million today is to house 677 inmates, and I apply the Director's square footage requirement of 40 feet per inmate, 40 feet times 667 is under 28,000 square feet. They're talking about building a 250,000-square-foot building. So if you only need 28,000 square feet for inmate living, what is the rest of the space for? I'm not taking issue. I think it's a good move and I think it's an excellent effort on their part to start to tighten their standards up, but, in fact, I don't think those standards—the standards that they are using today or that were cited today—have been implemented. I think maybe they're moving in that direction. I don't see it in practice.

We did a comparison to a BOP supermax facility in Colorado, and we applied what the Federal Bureau used for housing and other support spaces at that Colorado facility, and then we applied the same requirement using the State of Wisconsin standards for super-max inmates. The Colorado facility that Bureau of Prisons built is about 450,000 square feet. When we applied the Wisconsin standards, you only needed to build 225,000 square feet. That's half the size of the building. Well, when you do a turnkey development, a good benchmark is \$200 a square foot for all, everything you're ever going to want to spend to put that facility together. If you're overbuilding by 225,000 square feet times \$200, you're looking at \$40 million of extra money being spent.

Mr. MCCOLLUM. Well, your bottom-line point of all this—there are two bottom-line points I see, and correct me if I'm wrong, but one of them is that there are standards and ways that the Bureau of Prisons is doing business which really could be changed without radically altering the Bureau's needs and would be much more efficient. And, secondly, if more contracting out were done to private prison construction firms, such as, apparently, the work toward a more comprehensive plan for the Hawaii facility, then that would be a far more efficient way to go, too. I mean, those points are really what you're saying. I think Dr. Thomas' testimony goes along and dovetails into that, although you discussed a lot more about the management, not just the construction of prisons.

And I don't want to take a lot more time up because I can't today; we all are going to have to break from here. I need Mr. Scott and Mr. Barr to have some time. But I personally want to thank both you and Dr. Thomas particularly in this area because you're helping us a lot, and I hope we can call on you both to assist us as we work with the Bureau of Prisons trying to understand this better and to encourage them toward more privatization, more efficient utilization. I think Dr. Hawk wants to do that. I think there are some obvious discrepancies of knowledge right now which we all share—me, her, maybe you; maybe you don't. But I'm not going

to go on further because I've got to go to Mr. Scott, and I'd love to ask more questions, but my clock literally is running out.

Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman. I just have a couple of questions.

I think, Dr. Lipton, you were in the middle of answering a question on recidivism. One of the questions I asked was whether or not there was a difference in your ability to rehabilitate crack cocaine users and powder cocaine users.

Mr. LIPTON. Yes, I thought I answered that. The question is not a simple question; it's actually complicated. But, basically, it doesn't matter what drugs they use; it's not a drug issue; it's a person issue. And about, oh, 70, between, I'd say, 70 and—maybe 60 and 80 percent of all guys who are drug users, regardless of what drugs they use, can be rehabilitated with the appropriate modality, and it doesn't matter.

Now there is a difference between those who use those drugs. So people who use powder cocaine have—typically, are white, suburban, educated, jobs, and they have a whole variety of other support systems which inner-city crack users don't have. So you have to hold all those things constant to look at whether treatment resources are going to be applicable.

However, with potent resources like we've been talking about, the Stay'n Out program, and so forth, then you're able to override those differences. It doesn't matter whether they use those.

Mr. SCOTT. Well, I think Dr. Rabkin had in his testimony a figure of \$21 million that we're spending on drug rehabilitation in prison. Based on the amount of money we're putting into prisons, is it your suggestion that we spend a lot more money on drug rehabilitation?

Mr. LIPTON. Yes.

Mr. SCOTT. OK. As an incentive, you alluded to abolishing parole, which has been done in the Federal system. Some State systems have not abolished parole. When you can have a sentence 1½ years to 10 years, you get out when you've gotten yourself straight, do you acknowledge that that's quite an incentive to get into drug rehabilitation, if that's held over your head, where we can essentially keep somebody until they get their act straight as opposed to a situation where, ready or not, three years they're out?

Mr. LIPTON. Well, it's a matter of how long you have the right to hold someone in legal custody. Legal custody begins at the point of custody to the very end of that. And if you can have somebody on supervised release status of one kind or another, whether you call it parole or probation or some other name, you have the opportunity to intervene in their lives when they begin to screw up, and that's the whole point. If you take away that opportunity, then you finish a man's sentence and he's out. Then if he screws up, yes, you've got to rearrest him, but with supervision you have a much higher likelihood of being able to see that he's beginning to get reinvolved with drugs, reinvolved with crime, and bring him back into the system, and if he's been in treatment, to reinoculate him. But if he's not in any kind of supervised release, then it's strictly up to the police, and it's almost up to chance, because if you look

at the rates at which burglaries are converted to convictions, it's almost zero.

Mr. SCOTT. Thank you.

Mr. Thomas, you invited us to ask you about the question whether or not privatization will expand civil liberties. I'll bite.

Mr. THOMAS. It's simply a reflection of the way the courts have interpreted the relevant legal provisions, especially at the local and State level. Most of the litigation being brought against the localities and the States is brought under Federal civil rights law, under 42 U.S.C. section 1983. The manner in which the Supreme Court has interpreted what the objectives of the suits can be has limited prisoner plaintiffs who bring actions against State correctional agencies in practical, though not technical terms to prospective injunctive relief. It is now clear from other decisions of the Court that, if the same service were provided by a private rather than a public entity, they, being persons within the meaning of section 1983, can be sued directly and for money damages. It would also appear that the public policy rationale of the Court which has exempted, for instance, municipalities from being sued under section 1983 where there's a quest for punitive damages, is inapplicable to private party defendants. The bottom line is that if there is a deprivation of a constitutional right by a private entity that satisfies the State action and color of law tests, then the prisoner plaintiff can go to that entity for money damages.

Mr. SCOTT. And, essentially, the idea is that the private agency, the private sector would not have the immunity that a governmental agency would have?

Mr. THOMAS. As a matter of law.

Mr. SCOTT. OK, thank you.

Mr. Chairman, thank you.

Mr. BARR [presiding]. Thank you, Mr. Scott.

Mr. Rabkin, I'd really like to have some thoughts from you in followup to both some of the testimony of Dr. Hawk's as well as some of the testimony here with this panel on privatization of health services for prison inmates at the Federal level.

Mr. RABKIN. Mr. Barr, it seems to me that the testimony has raised some very interesting research and evaluation questions about what the actual costs are and whether they are comparative or comparable, and there's also the problem of balancing the three legs of the stool: the access, the quality, and the cost. And to the extent that they are measurable, that perhaps there should be some comparisons, and I think, as Dr. Shapiro said, that there is plenty of data out there in terms of the State and local prison systems that have offered—

Mr. BARR. Not according to Dr. Hawk.

Mr. RABKIN. Well, there certainly are data out there. There are prison systems that have experienced using contracts to provide the health care. In fact, the Federal Government does from time to time, when they don't have the capacity to provide certain care, they have to go out and buy it. And so all I'm suggesting is that there is an opportunity to do the evaluations and that, from my perspective, I couldn't conclude as to which systems are more cost-effective without seeing those kinds of data.

Mr. BARR. Would—is this something that GAO will be looking into? I think it is really ripe to study this in light of some of the testimony today and some of the activities such as Dr. Shapiro's company has been involved in.

Mr. RABKIN. If requested, we certainly would try to do that. There's another group within GAO that handles all the health care work, and they're the ones that have done a lot of the work so far on this. And to the extent that they have resources available to do that, I'm sure we would be glad to.

Mr. BARR. OK. Dr. Shapiro, do you have some more—I suppose the answer to this is almost certainly yes—some more detailed information that you could provide to me? I'd like very much to obtain some additional data on your experiences in this area.

Dr. SHAPIRO. Sure.

Mr. BARR. So I think it would be very, very worthwhile.

Dr. SHAPIRO. Let me just add, if I may—

Mr. BARR. Certainly.

Dr. SHAPIRO. If you look at the trends out there, almost 40 percent of the large jail systems, big cities, big counties, are now privatized. Three years ago less than 25 percent were privatized. If you look at States, they've been moving, under both Democrats and Republicans, more and more toward privatization of health care. And no one who has ever gone private has gone back except in one instance, and it was a political decision. The quality goes up because the inmates have expanded rights under section 1983. So if there's a problem, they can sue us where previously they couldn't sue the Government—we're held accountable. And because we're publicly traded, we're held accountable on the quality issues and the civil rights issues, and the courts have more and more been looking to private firms rather than governments to provide this because government bureaucracies at the State and local level are not terribly good at health care. That's not their mission.

We've been brought in under court monitoring systems repeatedly because the issue of the GAO studying cost and quality is going to be very difficult. They can do the cost study relatively easily, and I say "relatively" because it's going to be difficult to find apples to apples because of the way data is collected. There's data out there now of what many States are paying, but it will be a mixture of what's in that cost. Then it will take months and months and years to really flesh that out because the States often don't even now what costs are included.

On the other hand, on the quality piece, because no one's been able to really measure quality, whether we're talking about the VA or whether we're talking about our own health plans that we have, to study that leg of that stool is going to be a morass that no one will ever come out of. And so I look to the litigation and the accountability and talking to the prisoners. I go into prisons and jails and I talk to the prisoners. That's my job as CEO. I don't do the health care; I talk to the inmates; I talk to officials, and they tell us time and time again things are much better under privatization because we're held accountable to our stockholders and we're also held accountable to the State governments or the city governments and to the courts.

So the quality issue I think is going to be very difficult for GAO to study in a meaningful way. They could do the cost comparisons, but I think those comparisons have been done. And there was one out of the Texas controller's office that showed what the costs were.

Then if you look at what the cost—whether you take Delaware or Maryland, the costs have been coming down over the last couple of years because it's been a competitive business and it's freeing up dollars for security, which is why people are in prisons to begin with. So we're accountable for quality.

If we make mistakes, we're held accountable, and it's in our best judgment to practice good preventive medicine. We have chronic disease clinics for hypertension because we don't want the inmates to have strokes because we're held accountable for catastrophic costs where we don't have catastrophic limits. So if they have a stroke, then we're responsible for those costs. So even on an economic basis, forgetting the humane basis, we want to treat their hypertension, their seizures, their diabetes because we want to keep those costs well under control. And I think that's what all the studies—and the gentleman next to me, while he's not researched health care specifically, I think can say that the health care has generally been better and less expensive under privatized medicine.

Mr. BARR. Given the still fairly lucrative market for health care professionals in the country, how is your company able to provide health care professionals with a level of education and experience that's equal to or better than that of BOP employees?

Dr. SHAPIRO. I think for a number of reasons. One, we pay better than the BOP. Five years ago we had trouble recruiting doctors. We don't today. Good doctors are fed up with the private practice of medicine and are now looking to simply say, "Give me \$110,000 a year. Give me a secure environment, and I'll come in and practice from 9 to 5 and I'll take calls on a rotational basis," and this is happening across the country.

And the quality of the doctors that we're getting today is so much better than five years ago. We have medical directors at every institution where we practice. We have quality assurance screens. It's actually much tougher recruiting physicians' assistants today than doctors, and we have no trouble getting quality doctors, whether it be in rural West Virginia or whether it be in Georgia. Your own State of Georgia has said: "We'd rather have a private firm do the recruiting without the civil service regulations, where we can say, 'Doctor, we need you to work today from these hours,' in order to provide the flexibility." It's not an issue today. It was 5 years ago, but the quality of the doctors is dramatically improved, and people don't want to work for the Federal Government.

Mr. BARR. Thank you very much, Dr. Shapiro.

Just briefly, Mr. Rabkin and Dr. Thomas, do you have any thoughts, is there any statistics or is there any information that would indicate that in those institutions that have been privatized, whether there is either more or less security problems in terms of escapes, walkaways, or inmate violence?

Mr. RABKIN. I don't have any data on that.

Mr. THOMAS. There are some preliminary data on the escape issue suggesting that, in the aggregate, the incidence of escapes from private facilities is lower than from public facilities, but I



think it's not an apples-to-apples comparison in the sense that most of the privately managed facilities are of relatively recent design and construction, while many of the public facilities, 25 percent or substantially more are old, poorly designed facilities.

Mr. SCOTT. Mr. Chairman.

Mr. THOMAS. But it has not been an issue in terms of the debate that's going on now.

Mr. BARR. OK. Mr. Scott.

Mr. SCOTT. Could you yield for just a second?

Mr. BARR. Certainly.

Mr. SCOTT. Have any high security prisons been privatized?

Mr. THOMAS. The first full max privatization initiative coincidentally was by a Federal agency, the U.S. Marshals Service. They provided for a contract with the Corrections Corp. of America for a facility located in Leavenworth, KS, that holds the most difficult, the highest security risks that the U.S. Marshals Service is responsible for. There are other maximum security facilities, but that was the first full max facility.

Mr. SCOTT. I was under the impression that most of the privatizations were for the low security.

Mr. THOMAS. If you went back to perhaps 1984, 1985, or 1986, that would have been true. They tended to be for minimum security facilities of between 150 and 500 beds. What we're seeing today is that the overwhelming majority of the contract awards are for facilities of 1,000 to 2,000 with the custody mix tilting toward the medium and higher end of the continuum, but that's where the prisoner population nationally is going. I mean, you don't see that many Sunday school truants anymore. They tend to be some somewhat more difficult folks to manage.

Mr. BARR. OK, was there anything else, Mr. Scott?

Mr. SCOTT. Could I ask a question of Dr. Shapiro?

Mr. BARR. Certainly.

Mr. SCOTT. What is the length of your contract on providing the service?

Dr. SHAPIRO. It varies from contract to contract. Sometimes they're 1 year; sometimes they're 2 years; sometimes they're 3 years. In the State of Georgia it's 5 years. In the State of Maryland it was 2 years with two 1-year option years at the State's and our decision, all competitively bid. Sometimes they're put out for a 1-year bid with renewals. It's varied from one to 5 years.

Mr. SCOTT. The longer your contract, the more incentive you have to do preventive health care; is that an accurate statement?

Dr. SHAPIRO. I don't think so. If we were a sleazy company, that would be. However, there's so much scrutiny and there's competition out there, and reference checks take place, that the reality is that you've got to take care of business and treat inmates. And I won't tell you that one of our competitors, if we're going to take over the contract from them, won't delay a hernia operation that's not emergent and dump it on us, but we won't do that, although they might say differently. [Laughter.]

But I tell you that we will not do that consciously because we view ourselves as the quality provider, and we have to be because we're the only publicly-traded company that's strictly in this business. So our books are so open because we can't bury our correc-

tional health care business. There's a couple of megacompanies that have small prison health care business, so they bury what they're doing in that, but we can't. So we're accountable, and I do not know of a single instance where we've done that because it comes back to haunt you. It really does.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. BARR. OK. Thank you, and I'd like to thank all members of this panel. It's been very, very enlightening. We appreciate the extra time that you've put in, the materials that you've provided. And if any of you have any additional materials, please feel free to provide those and they will be incorporated. And, Dr. Shapiro, in particular, I'd personally like to receive some additional information from you.

Dr. SHAPIRO. Great. I'd be glad to do that.

Mr. BARR. Thank you.

Thank you all. We're adjourned.

[Whereupon, at 1:21 p.m., the subcommittee adjourned.]

# APPENDICES

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## APPENDIX 1.—A FEASIBILITY STUDY BY DOUGLAS C. McDONALD, ABT ASSOCIATES INC., ENTITLED, "PRIVATIZE FEDERAL PRISON HOSPITALS?"

### PREFACE

In 1988, the Office of Management and Budget requested that the National Institute of Justice study the feasibility of contracting with the private sector to manage or operate any of the hospitals that are currently being run by the Federal Bureau of Prisons. To conduct the study, the National Institute contracted with Abt Associates Inc.

The study was directed by Douglas C. McDonald, Ph.D., who was assisted by Joan Mullen, Managing Vice President, Law and Public Policy Area; and by Francoise Clottes, Vaira Harik, and Peter Feng, Research Assistants. The Abt Associates advisory committee for the project included:

Gary Gaumer, Managing Vice President, Health Research Area

Joseph Smith, Ph.D., Deputy Area Manager, Health Research Area

Scott Honiberg, Senior Associate, Business Strategy Group

Stephen Kennedy, Ph.D., Abt Associates' Chief Scientist.

Stephen Kennedy also served as Technical Monitor. Geoffrey Laredo served as the project monitor for the National Institute of Justice.

An external advisory board was also established to review the study's report. Members of this board included:

Professor Mark Schlesinger, Department of Public Health and the John F. Kennedy School of Government, Harvard University

Professor Jeffrey Alexander, Department of Health Service Management and Policy, School of Public Health, University of Michigan

B. Jaye Anno, Ph.D., Vice-President, National Commission on Correctional Health Care

Abt Associates and the National Institute of Justice are grateful for the contributions of these advisors to the project.

Finally, the study could not have been accomplished without the cooperation and assistance of many officials at the Bureau of Prisons. We are especially grateful to Kenneth Moritsugu, M.D., the Director of the Bureau's Medical Services Division, and Wade Houk, Director of the Bureau's Administration Division, for making their staffs available to us. In addition to others at the Bureau's Washington, D.C. headquarters, we

were assisted by numerous officials at the Federal Medical Center at Rochester, Minnesota, the Federal Correctional Institution at Lexington, Kentucky, and the Medical Center for Prisoners in Springfield, Missouri.

Douglas C. McDonald, Ph.D.  
Senior Social Scientist  
Abt Associates Inc.  
Cambridge, Massachusetts  
May 1990

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## INTRODUCTION

In a guidance document to the Department of Justice, the Office of Management and Budget requested that:

During 1989, the National Institute of Justice is to conduct a study of the feasibility of contracting the management and operation of prison hospitals to the private sector to be completed by September 30, 1989. If the study indicates that private management and/or operation is feasible, a pilot project should be conducted in 1990. The study should examine all prison hospital functions--medical and custodial; review relevant Federal, State, and local government experience; and identify private sector interest. It should also address unique security, continuity, insurance and care vs. custody issues, and should identify which functions and which hospitals provide the best private sector opportunities.

Three criteria were considered in assessing feasibility:

**Ease of implementation:** This includes political considerations, legal constraints, and practical considerations. Political considerations include such things as the likelihood that public employees will oppose privatization, or the possibility that privatizing a prison hospital will diminish other valued interests of other groups or constituencies. Legal considerations include whether there is sufficient legal authority to delegate operational authority to a private firm, and whether there are special liability issues that will diminish or limit feasibility. Practical considerations include whether there are likely to be private firms interested in the proposed project, whether these firms have adequate experience in this field, and the extent to which the market for such services is competitive.

**Effects on the quality of service delivery:** This includes considerations of whether quality of care, the stability of delivery, and accountability/quality control issues will be affected by privatizing management and/or operations.

**The costs to the Federal government of contracting:** These include considerations of whether contracting will increase efficiency, so that the same services are provided at a lower level of expenditure, or that the same level of expenditure will yield more or higher quality services and whether contracting will incur other costs (for increased security, for example).

To carry out this study, we interviewed a number of officials at the Bureau of Prisons to determine how services are currently being delivered and conducted on-site inspections of three hospitals in the system: Rochester, Minnesota; Springfield, Missouri; and Lexington, Kentucky. These three receive all referrals for medical or surgical treatment within the Bureau. (A fourth hospital, at Butner, North Carolina, provides only psychiatric treatment and was not visited, nor were two smaller referral

centers at Fort Worth, Texas, and Terminal Island, California.) We also collected and analyzed a variety of data pertaining to budgets, expenditures, utilization, staffing, and organizational structure of the referral centers, reviewed the published literature on contracting for hospital management and operations, and conducted an examination of state and local governments' experience with contracting for health services. As a part of the latter task, we interviewed officials in a number of jurisdictions by telephone, examined contracts, analyzed a variety of other data including financial data, and interviewed officers of selected contracting firms.

### Structure of this Report

Chapter One provides a thumbnail description of both the hospitals operated by the Bureau of Prisons and the larger health care system in which they are a part. We have considered the potential effects of privatization not only on the hospitals themselves but on the entire system. Chapter Two estimates the costs of services in the referral centers and explores the reasons for the differences among centers. Chapter Three addresses the feasibility of contracting management or operational responsibility for a prison hospital. Chapter Four explores the possible fiscal consequences of contracting. Chapter Five examines the possible effects of private contracting on the delivery of health care services in the hospital itself and in the larger system. Chapter Six explores some alternatives to privatization. Selected state and local experiences with contracting for correctional health care services are reviewed in Appendix A. Appendix B provides more detailed information on how the cost estimates were derived.

## SUMMARY OF PRINCIPAL FINDINGS

### The Feasibility of Implementing a Privatization Initiative

- Contracting for total managerial and operational responsibility of an entire prison hospital ("referral center") is infeasible because each of these facilities is but a division of a larger prison, with which it shares services and staff.
- Transfer of ownership of any referral center is also infeasible, given the absence of a competitive industry for operating prison hospitals, because the likelihood of thereby creating a monopoly provider is too high.

- Consideration of privatization should be limited to contracting for (1) the management and/or operation of all or some of the clinical services at the referral centers, or (2) for some specific management services, such as utilization review.

- The feasibility of finding an interested and qualified bidder for the management or operation of a prison hospital is uncertain, given the absence of firms with such experience.

- The constraints imposed upon the referral centers by their place in the larger Bureau of Prisons' health care network may make the prospect of administering them uninteresting to firms experienced in managing free community hospitals.

- Firms with experience providing correctional health care under contract with state and local governments specialize almost exclusively in providing outpatient care to prisoners, and have almost no experience administering hospitals. The sole example of a prison hospital under contract management in the country appears to be a recently-converted facility in Georgia, which began operations during the summer of 1989.

- Local hospitals may be interested in assuming managerial and, perhaps, operational responsibility for a referral center. Competitive conditions for soliciting bids from local hospitals exist in four of the six referral centers (Springfield, Lexington, Fort Worth, and Terminal Island).

- Experimenting with privatization at the Springfield center is not recommended because it is the workhorse of the national health care network, and the risks of disrupting the operations of that national network are too great.

- If the Bureau determines that there is sufficient reason to experiment with contracting either for the management or operation of a particular referral center, issuing a Request for Qualifications and Interest would test the availability and interest of potential contractors.

### **The Potential Effects of Contracting on Service Delivery**

- Reviews of the experience of contract management of hospitals in the free community, and of the state and local experience with correctional health care contracting, do not suggest that the quality of patient care will be adversely or positively affected by contracting.

- Contracting may help relieve the referral centers' inability to achieve full staffing levels. While the Bureau's staffing problem is due partly to nationwide shortages of certain types of health care professionals, it is exacerbated by a non-competitive salary structure. Similarly, non-competitive pay scales have led state and local governments to turn to contracting as a technique to recruit needed staff (because contractors are not bound by government pay schedules, permitting them to pay higher salaries).

- The alternative to achieving full staffing by contracting is to raise government employee salaries to more competitive levels, and to undertake more aggressive and more expert recruitment.

- Fully staffing the referral centers, by either contracted or government employees, will probably speed up the treatment of medical/surgical patients at the Lexington, Springfield, and Rochester centers, shortening their length of stay. The net effect on the total cost of treatment per admitted patient is unclear, but it might reduce demand for acquisition or construction of new referral centers.

- Contracting for a referral center in which all clinical staff are paid at a much higher rate would create a two-tiered health care system in the Bureau, which may prove disruptive.

- Contracting also incurs a risk of disrupting the Bureau's national health care system if contractors fail to perform as expected, go out of business, or experience other types of financial instability. The cost of reassuming control of a failed contractors' operations may be substantial when the Bureau already has difficulty hiring sufficient numbers of staff for its existing referral centers.

#### Possible Effects of Contracting on Spending for Health Care

- Spending for prisoner health care in the Bureau is not experiencing the severe run-up that some fear. Although expenditures for health care in the Bureau have been increasing rapidly in recent years, this increase is accounted for entirely by the rising numbers of inmates under custody and inflation in the cost of health care services. Real per capita spending for prisoner health care has, consequently, remained the same between 1984 and 1989.

- The average cost per admission in the four major referral centers was higher during 1988 than in community hospitals: between \$9291 and \$15,236, compared to the national average of \$3733 in community hospitals that year. This was the result

of very long lengths of stay in the referral centers (averaging between 49-129 days), compared to the national average of 7.2 days in community hospitals.

- The average daily costs of inpatient treatment at the referral centers are low, averaging between \$65 and \$248 per day during FY 1988. This was much lower than the cost of hospitalization in the free community, which averaged \$523 per day during the same period. (This difference is partly a function of the large difference in lengths of stay. Patient stays in free community hospitals are shorter and more treatment-intensive, and, consequently, more costly.)

- Low wages paid to staff and the understaffing of the referral centers contribute to the low average daily cost of hospitalization.

- There is some evidence that understaffing contributes to the extended lengths of stay.

- Relieving the referral centers' recruitment bottleneck by contracting will probably result in higher labor costs, which will translate into higher expenditures for health care, unless contractors are able to substitute lower-paid professionals for higher-paid ones, or unless contractors are able to achieve greater productivity from higher-paid staff.

- The Bureau's referral centers already make heavy use of lower-paid physicians' assistants and licensed practical nurses, suggesting that the opportunities for cost reduction by staff substitution are limited.

- The cost of medical labor will rise within the Bureau of Prisons even in the absence of contracting because the supply of obligated scholars--Public Health Service physicians working off their school debts at low salaries--is drying up, which will require the Bureau to hire physicians at much higher salary levels.

- The security component of hospital costs will not be affected by contracting, except perhaps to increase somewhat, depending upon policies that the Bureau establishes to govern the contractor's custodial responsibilities and duties.

- The remaining components of hospital costs (supplies, food, housekeeping, etc.) are not likely to be reduced significantly because they are already very low, and because the referral centers take advantage of nearly-free inmate labor and a variety of services shared with the larger prison.

- Because there appears to be so small an opportunity to reduce per diem hospital costs, the only obvious avenue for reducing costs would be shortening patients'

length of stay in the referral centers. For a variety of reasons peculiar to prisons, these stays are far longer than anything found in the free community. There are substantial constraints on being able to shorten stays; unlike most patients in private hospitals, prisoners generally need to complete convalescence before returning to prison. Despite such constraints, treatment might be speeded up if staffing levels were increased.

- Firms that provide full-service management services to hospitals in the free community have not typically relied on cost-reduction but instead on aggressive marketing and revenue-generating strategies. Opportunities for these business strategies are not available in the Bureau of Prisons.

- Some benefits may be gained from contracting for specialized services. These may include departments within the referral centers that are unable to staff up sufficiently because of labor shortages, or departments that are especially amenable to cost-reduction by a national firm or local hospital achieving more advantageous economies of scale.

## Endnote

1. Internal memorandum, undated.



## CHAPTER ONE

## THE BUREAU OF PRISONS' HEALTH CARE SYSTEM

The Bureau of Prisons' hospitals, known as "referral centers," are not autonomous units but integral parts of a larger nation-wide health care delivery system. That larger system includes outpatient and inpatient services, affording primary through tertiary care, and is provided by government employees in Bureau-owned facilities, private-sector providers working as consultants or contractors, and a large number of private and public non-correctional hospitals. This chapter will describe the system as a whole; more detailed information about individual referral centers follows in later chapters.

**The Structure of the Larger System and the Role of the Referral Center Within It**

As of late 1989, the Bureau's nation-wide health care delivery system consists of six prisons with referral centers and forty-eight prisons without referral centers. Inmates from any prison in the system can be transferred to a referral center for hospitalization. They also may be sent to neighboring private or public hospitals. Prisons with referral centers also utilize the services of nearby community hospitals in some instances.

The Health Services Division of the Bureau is in charge of administering all health care to the prisoners under the Bureau's jurisdiction. Under a cooperative agreement with the U.S. Public Health Service, the Bureau staffs the management team of the Division with PHS officers, and PHS officers (mostly physicians) provide much of the service in each of the referral centers. At present, the medical director of the Health Services Division is an Assistant Surgeon General in the PHS. In addition to these PHS officers, the Bureau has its own employees assigned to the Health Services Division. Both Bureau and PHS employees have correctional as well as clinical responsibilities, and all are given correctional training.

**Outpatient Care**

In the prisons that have referral centers on site, inmates receive outpatient services from the medical staffs of these referral centers. In the other 48 prisons, outpatient treatment is performed in the facilities on a routine basis. This includes physical examinations and visits made during the daily sick call. These services are

provided by doctors as well as physicians' assistants. The doctors include those employed by the Bureau or the Public Health Service as well as private physicians from the community who are called into the prison to provide consultations. If additional services that cannot be provided within the prisons are needed, inmates can be transported to a nearby community hospital for laboratory and diagnostic testing and consultation with other physicians. Inmates are escorted to community hospitals under guard, with correctional officers accompanying them at all times.

Table 1.1 shows the number and distribution of outpatient visits throughout the Bureau's nation-wide system during a three-month period sampled in 1988, when there were approximately 44,000 prisoners in the Bureau's custody. (The information is not complete as records for four prisons were not located at Bureau headquarters.)

Table 1.1  
Outpatient Visits in the Bureau of Prisons  
Health Care System, Fourth Quarter FY 1988

	Outpatient Visits to BOP/PHS Staff	By Consultants Coming Inside Prisons	By Consultants Seeing Prisoners Outside Prisons	Physical Exams by BOP/PHS Staff
Referral Centers	61395 (24%)	11021 (23%)	1169 (27%)	5297 (17%)
Fort Worth	9489	6	143	796
Terminal Island	13705	618	109	1758
Butner	4763	772	43	384
Lexington	12010	5006	210	1041
Rochester	5847	3190	365	196
Springfield	15581	1429	299	1122
Other Institutions	<u>193085 (76%)</u>	<u>36283 (77%)</u>	<u>3116 (73%)</u>	<u>26227 (83%)</u>
TOTAL	254480 (100%)	47304 (100%)	4285 (100%)	31524 (100%)

SOURCE: Computed from BPmed3 reporting forms from each facility, 4th Qtr. 1988. Reports were missing for the prisons at Terre Haute, Pleasanton, Miami, and Leavenworth; the totals shown here for all "other institutions" are therefore lower than they actually were during that quarter.

During this three-month period, 320,106 outpatient visits by prisoners were recorded, 25 percent at the referral centers and the remainder occurring at other prisons. 254,480 of these visits were performed by government-employed Bureau or

Public Health Service medical personnel; 47,304 were conducted by medical consultants coming into the prisons; 4,285 visits were to consultants located outside the prison, typically at a local community hospital. 31,524 of these outpatient visits were for physical exams by Bureau or Public Health Service staff.

#### **Inpatient Care and the Choice of Providers**

Inpatient care is provided in two different types of hospitals: the referral centers and hospitals in the surrounding communities, whether public or private. The decision to route patients to the local community hospital or to transport them to a Bureau hospital for treatment is made at two levels. Once a clinical decision is made at the prison level to refer a prisoner for inpatient treatment, a Bureau-employed health service administrator makes a first-cut decision about sending him or her to a local hospital. In the case of emergencies, there may be no choice but to take the prisoner under guard to a nearby hospital. Where more latitude exists, the health service administrator weighs a number of factors to determine whether to request transfer to a referral center. These include the expected cost of obtaining the service in the nearby hospital, the security level of the prisoner, and the urgency of treatment. The local community hospital is preferred when the expected treatment is likely to be inexpensive; however, the Bureau is generally unwilling to send high-security inmates into the community and will opt for one of the referral centers. (Aside from the increased risk of an escape attempt, which may involve encounters with potentially dangerous confederates of the prisoners, many communities are understandably nervous when dangerous criminals are transported beyond prison walls.) In February 1990, 5% of all the Bureau's prisoners were classified in the high-risk security levels (5 and 6), 19% in level 4, and 66% in the lower-risk levels (1 through 3). (The remaining 10% were unclassified.)<sup>1</sup>

If the health service administrator determines that transfer to a referral center is either preferable or necessary, a call is placed to the "medical designator," a Bureau official located in the Washington, D.C. headquarters. This designator keeps track of the availability of beds in the various prison hospitals and is charged with choosing the treatment hospital.

Transportation by normal means (prison buses) is often a long process, requiring that inmates stay overnight in local county jails along the way as they move across the country to one of the medical centers. When quicker transport is needed, an

inmate may travel by air ambulance, air charter, or commercial airline. Transportation is made under guard, and prisoners are confined with handcuffs and leg-irons.

In some instances, prisoners transferred to the referral centers for treatment are sent outside to local community hospitals, and then returned to the referral center. For example, a prisoner sent to the referral center at Springfield for cardiac illness will be sent to a local hospital if complicated surgery is required that cannot be provided in-house. Prisoners may be sent to the Rochester referral center precisely because they are expected to enter the nearby Mayo Foundation hospitals for specialized or complicated treatment. Following treatment, patients may then be brought back to the referral centers for extended recovery.

In some cases a prisoner may be sent from one prison to another, and not to a referral center, because the second prison is near a community hospital that is better able to provide the service needed. The cost of the service may be lower, or more reliable, than what could be provided near the first prison.

The Washington-based "medical designator" is therefore the principal regulator of the system. He determines when private rather than Bureau provision will be given, which has significant cost implications. He regulates demand for each of the referral centers within the system, because demand can be "bled off" to other private or public hospitals. Thus the "market" for patients of the referral centers is very different from the market of a typical hospital in the free community. This inability to control demand (more precisely, admission) limits the capacity of the for-profit hospital management firms to use many of the management strategies they have developed for non-correctional hospitals, as shall be discussed below.

Table 1.2 shows how demand for inpatient treatment was distributed throughout the Bureau's system, in the referral centers and in local community hospitals, during Fiscal Year 1988. (The federal fiscal year runs from October 1 through September 30.) The units counted here are the average daily number of beds occupied by federal prisoners. Admissions data would show a significantly different picture as the average length of stay in a referral center is much longer than that for standard hospitals, as discussed below.

Table 1.2

Average Daily Patient Load in the Bureau of Prisons'  
Health Care System,  
FY 1988 (Estimated)

	<u>In Bureau Institutions</u>				<u>In Community Hospitals</u>			
	MED	Type Treatment: SURG	PSYCH	TOTAL	MED	Type Treatment: SURG	PSYCH	TOTAL
Butner	0	0	114	114	0	0	0	0
Lexington	34	5	23	62	3	2	0	5
Rochester	56	5	58	119	1	1	0	2
Spring.	263	151	288	702	1	1	0	2
Fort W.	6	0	0	6	0	0	0	0
Term. Is.	7	3	6	16	1	0	0	1
<hr/>								
TOTAL REFERRAL CENTERS	366	164	489	1019	6	4	0	10
OTHER PRISONS	15	4	13	34	106	7	0	131
<hr/>								
TOTAL BOP	381	168	502	1053	112	11	0	141

Source: Computed from the BPmed3 forms provided by all facilities; monthly forms for the entire year were tallied for the biggest four referral centers (Butner, Lexington, Rochester, Springfield); for all others, a sample was drawn, consisting of all forms for the 4th quarter FY1988, and results were annualized.

The average daily inpatient load in the system, during Fiscal Year 1988, was estimated at 1194 prisoners, 1053 (or 88%) of whom were hospitalized in one of the Bureau's prisons rather than in community hospitals. Of the 1,053 persons in the Bureau's care, 1,019 (or 97%) were held in one of the six referral centers. The remaining 34 were in infirmaries in the other Bureau prisons. (The infirmiry capacity in these other prisons is limited: no more than about 70 beds exist throughout the system.) As the table shows, the referral centers sent prisoners to nearby community hospitals almost exclusively for medical treatment and surgery. Nearly all psychiatric patients were in the referral centers, mostly at Springfield (288) and Butner (114). At the referral centers, these psychiatric patients occupied the largest bloc of beds -- nearly half of all beds in the system. About a third (366) of the referral center beds were filled with medical patients, and 16 percent with surgery patients. Springfield is

the workhorse of the system. It handles about 70 percent of all patients in the referral centers (and nearly 60% of all patients in the entire system). It has by far the largest number of surgical patients (90% of the total throughout the system), medical patients (69% of the total system-wide), and psychiatric patients (57% of the total system-wide).

The forty-eight prisons without referral centers have a limited capacity for housing inpatients. During Fiscal Year 1988, as Table 1.2 shows, an average of 34 beds in these prisons were occupied each day by prisoners needing medical, surgical, or psychiatric care. These inmates are housed in small infirmaries within the prisons, either for observation or recovery from outside hospitalization (usually in local community hospitals); the infirmaries also may house inmates awaiting transfer to a referral center. Hospitalization in nearby community facilities occurs almost always for medical rather than surgical treatment, reflecting the Bureau's preference for using referral centers for surgery.

### The Referral Centers

#### Springfield, Missouri

Built in 1933, The U.S. Medical Center for Federal Prisoners in Springfield, Missouri, is designed to house 1163 inmates, including approximately 800 medical, surgical, and psychiatric patients of all security levels (i.e., minimum-security through maximum-security prisoners). The remaining inmates are not patients but prisoners in the "general" population, who constitute a "work cadre" to support the operations of the facility. There are a total of 670 employee positions authorized. During Fiscal Year 1988, Springfield spent \$28.6 million for total facility operations; \$12.3 million was spent for health care services, defined narrowly to exclude the cost of security, general administration, and a variety of other cost centers.<sup>2</sup> This understates the cost of the hospital, however, because the entire facility exists principally for medical purposes.<sup>3</sup> The hospital has been accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the laboratory by the College of American Pathologists (CAP).<sup>4</sup>

Springfield provides a variety of services directly, including surgery, but it also relies on the services of consultant physicians for specialist/sub-specialist services, and on three local hospitals for the most complicated surgeries. The center does not have sufficient equipment or staffing of operating rooms and laboratories to support complicated and risky surgeries.

The center has four housing units: a medical unit (244 beds), a surgical unit (262 beds), a psychiatric unit (255 beds), and a 352-bed "general population" unit. A special "Cuban unit" of 50 beds is composed of Cuban prisoners transferred to Springfield after riots at Atlanta and Oakdale; most of the Cubans are housed with the psychiatric unit. The general population unit consists almost exclusively of a "work cadre" for the referral center. Before Fiscal Year 1987, the general population had been larger, but medical and mental health units were expanded, which shrank the size of the general population. Nearly all of this reduced general population serves as the work cadre. The mental health unit includes divisions devoted to treatment and evaluation of sentenced prisoners as well as forensic diagnosis and observation of unsentenced prisoners for the federal courts.

#### Lexington, Kentucky

The Bureau's major medical facility for women is located on the site of the Federal Correctional Institution in Lexington, Kentucky. At one time a hospital run by the U.S. Public Health Service and the National Institute of Mental Health, the entire complex was converted to a federal prison in 1974. The Lexington Prison now serves as the principal women's facility in the system, housing approximately 1,300 (about 40%) of the roughly 3,000 female prisoners in the Bureau's custody. The medical facility has a total of 85 beds, with 25 beds in its medical unit, 22 in its surgical unit, and 38 in its psychiatric unit. A total of \$20 million was spent during Fiscal Year 1988 to support the operations of the entire facility, \$6 million of which was spent for health care services.<sup>5</sup>

Lexington makes heavy use of three community hospitals because its surgical facilities are outdated, and because the physical structure of the referral center cannot accommodate the necessary renovation to make the facilities adequate. In addition, all deliveries/births are performed at local hospitals. This explains why Table 1.2 shows more extensive use of outside hospitals by Lexington than by the other referral centers.

#### Rochester, Minnesota

In 1984, the Bureau acquired a former state mental hospital and opened it in September 1985 as the Federal Medical Center, which operates as a prison and another acute care referral center. The entire prison houses almost 700 inmates. During 1988, extensive hospital renovation was completed and inpatient and outpatient services were reorganized, enabling the center to treat difficult and complex medical or surgical

cases, as well as psychiatric cases. It serves mainly low- to mid-security male inmates, although a few females have been admitted.

During Fiscal Year 1988, Rochester housed medical and surgical patients in 120 beds and mental health patients in 120 beds. In addition, there is a 48-bed treatment unit for inmates with chemical dependency problems. (Recently, the number of beds for medical and surgical patients was expanded to 180.) The facility also has a contract with the Mayo Foundation (the governing entity for the Mayo Clinic and associated hospitals) for a variety of special services. Like the Springfield facility, the ability to perform extremely risky or complicated surgeries is limited by the absence of round-the-clock physician and laboratory coverage. Such surgeries are performed in the local hospitals. Rochester is accredited by the JCAHO.

As in Springfield, the hospital's mental health unit provides treatment and evaluation of sentenced prisoners but also forensic diagnosis and observation of unsentenced prisoners for the federal courts.

During Fiscal Year 1988, the cost of operating the entire facility was \$17.7 million, \$7 million of which was for health care services.<sup>6</sup> The average daily general population at Rochester was 628; the average daily patient census in the same period was 121.<sup>7</sup>

#### **Butner, North Carolina**

The Federal Correctional Institution at Butner is a 421-bed prison that has a 163-bed psychiatric unit. This center provides treatment for inmates who are overtly psychotic or suicidal, or persons who are referred by the courts for study and observation. It has no beds for medical or surgical cases; prisoners requiring medical or surgical care are taken to local community hospitals or transferred to other referral centers. During Fiscal Year 1988, the cost of operating the entire facility was \$11.4 million, \$2 million of which was spent for health care services.<sup>8</sup> Butner is accredited by the ACA and the JCAHO.

In addition to the four major medical centers described above, the Bureau operates two other smaller facilities.

#### **Terminal Island, California**

The Federal Correctional Institution at Terminal Island at Long Beach, California contains a small, 37-bed regional medical facility providing short-term medical care for male prisoners in the Western region. Most of the prisoners are



general population inmates, with 638 beds for sentenced inmates and 233 for detained inmates awaiting sentencing in federal courts. During Fiscal Year 1988, approximately \$13.2 million was spent to support all facility operations, including about \$1.9 million for health care (mostly outpatient care, including physicals).<sup>9</sup>

#### **Fort Worth, Texas**

A former U.S. Public Health Service Hospital, the Federal Correctional Institution at Fort Worth, Texas, opened in 1971. The facility has 660 beds, mostly for general population. The Bureau is in the process of establishing a long-term care unit for chronic patients at the facility; for Fiscal Year 1988, there were an average of 6 such inpatients. During Fiscal Year 1988, total facility operations cost \$11.4 million, with \$1.9 million spent for health care.<sup>10</sup>

#### **Trends in Spending for Health Care**

During Fiscal Year 1988, the Bureau of Prisons budgeted \$97.7 million for health care services.<sup>11</sup> In addition, \$9.3 million was spent by the Public Health Service to support officers assigned to the Bureau.<sup>12</sup> Between Fiscal Years 1984 and 1989, the Bureau's share of prisoner health costs increased 113 percent, from \$45.8 to \$97.7 million. Table 1.3 shows the budgets for total medical spending for each of the years since 1984. Also shown are the budgeted costs of current operations as distinguished from equipment purchases.

Table 1.3  
Bureau of Prisons'  
Budgets for Health Care, FY 1984-1989

<u>Year</u>	<u>Total Budget</u>	<u>Current Operations</u>	<u>Equipment</u>
FY84	\$45,750,283	\$45,205,345	\$544,938
FY85	54,964,015	51,525,209	3,438,806
FY86	62,525,186	61,602,111	923,075
FY87	76,595,422	73,583,267	3,012,155
FY88	84,943,478	82,080,292	2,863,186
FY89	97,737,419	93,856,767	3,880,652

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SOURCES:

Total budgets from "Total Medical Obligations by Year 84 thru 89, as of June 27, 1989," equipment budgets from "Total Medical Equipment Obligations for FY 84 thru 89 as of June 30, 1989," both provided by the Bureau of Prisons. Current operations are computed by subtracting equipment from total budgets.

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Most of the total budget was not spent for the referral centers. Rather, the major share of the Bureau's health care spending was for services provided by the forty-eight prisons that do not have referral centers on site. During Fiscal Year 1988, for example, the six referral centers accounted for 41 percent of the Bureau's total budgeted health care dollars, whereas the remaining forty-eight prisons spent 59 percent of all health care funds.<sup>13</sup>

Part of the increase in health care costs resulted from a growth in the numbers of federal prisoners under the Bureau's custody. During the 1984-1989 period, that number increased approximately 50 percent. Almost half of the increase in health care spending was attributable simply to having more prisoners.

Since spending for health care rose at a faster rate than the increase in the federal prisoner population, the average expenditure per prisoner increased. Between Fiscal Years 1984 and 1989, the average per prisoner rose about 40 percent, from approximately \$1500 to about \$2100 in current dollars. This apparent increase in per capita spending probably did not get translated into an equivalent increase in services, however, because the value of dollars spent for health care services eroded during this period. In 1989, according to the Bureau of Labor Statistics, a 1984 dollar bought 58 cents worth of health care services in the "basket" for which it tracks prices. If the value of Bureau-provided services inflated at this rate, the "real" (i.e.,

inflation-adjusted) cost of health care on a per prisoner basis actually remained stable during these five years. The value of the Bureau's services probably did not suffer the same rate of inflation as did services on the outside market, which means that the real per capita expenditure for health care probably increased a little between 1984 and 1989.

Health care spending did not grow at a faster rate than the Bureau's total budget during this period. Indeed, the rate paralleled the overall increase, so that the proportion spent for health care (10% of the total budget) remained constant over the five years. In real terms, this proportion decreased.

#### The Coming Demand for Health Care in the Federal Prisons

Spending will be increasing substantially for both Bureau-wide responsibilities and for prisoner health care in the near future. Since 1980, the federal prison population has been growing, first because of changes in federal drug law prosecution practices in the early 1980s, then the toughened sentencing practices that resulted from passage of the 1986 Anti-Drug Abuse Act, and finally the more general stiffening of penalties following the implementation of sentencing guidelines called for in the Sentencing Reform Act of 1984 (the provisions of which govern the sentencing of crimes committed after November 1987).<sup>14</sup> (See Table 1.4.) Absent dramatic changes in these laws, the Bureau's prisoner population will continue to grow quickly. The Bureau estimates that by 1995, the system will hold 94,000 inmates, compared to the 47,800 it held in 1989.<sup>15</sup>

Table 1.4

Average Daily Prisoner Population,  
Bureau of Prisons, FY 1975-1995

1975	23,007	1984	31,394
1976	24,967	1985	33,834
1977	28,741	1986	39,008
1978	29,347	1987	42,627
1979	26,077	1988	43,835
1980	23,918	1989	47,804
1981	24,933	.	.
1982	27,730	.	.
1983	29,718	1995	94,000(est.)

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SOURCE: Office of Research and Evaluation, Bureau of Prisons.

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In addition, the inmate population will be growing older; subsequently, the demand for medical care will increase. The "graying" of the federal prison population is partly the result of the aging of the broader U.S. population. Extrapolating from general population changes in age distribution and from current prison admission patterns, the Bureau estimates that by the year 2005, 16 percent of the prisoner population will be 50 years or older, compared to 11.7 percent in 1988. This is a conservative estimate, because the federal courts are imposing longer sentences, which will result in an even more pronounced graying of the prisoner population. No research has been done to determine how the age distribution of prisoners will be affected by both changes in sentencing practices and more general aging of the U.S. population.<sup>16</sup>

The Bureau has projected the increased costs attending the aging of its inmates. During 1988, the Bureau spent an estimated \$6.7 million for services provided by non-BOP providers to treat cardiac and hypertensive disorders among the population 50 and older. The Bureau's research staff extrapolates that by the year 2000, outside treatment for cardiac and hypertensive disorders will be \$10.1 million in constant 1988 dollars.<sup>17</sup>

Finally, the number of inmates with AIDS will continue to increase. The Bureau began random testing in 1987 and reports a steady 2.6 to 2.8 percent HIV-positive rate. This will result cumulatively in a significant overall increase in the numbers of federal prisoners with AIDS, because prisoners will be serving much longer sentences. Because inmates with AIDS consume a large share of health care resources, the fiscal impact of this disease on the Bureau's medical budgets could be large.<sup>18</sup>

### Planning for Expansion

The referral centers are now operating very close to full capacity. The medical designator estimates that about 10 percent of all requests for transfer to the referral centers are turned down for lack of space and are sent instead to local community hospitals for treatment. This occurs even though the referral centers are not 100 percent full, because the medical designator must retain some capacity to accommodate high-security inmates who require emergency treatment. (See Table 1.5, which shows the capacity and occupancy rates, by specialty, for each of the four largest referral centers during the fourth quarter of Fiscal Year 1988.)

To accommodate the health care demands of this growing population, the Bureau is currently considering several options for expanding its in-house capacity. One involves the acquisition of an existing hospital and then "hardening" it sufficiently so that it can serve as a prison as well. Whether or not it would be cost-effective to contract for the management of such acquired facilities, or whether to expand in-house capacity at all, or to what extent, is discussed in subsequent chapters.

Table 1.5  
Bed Capacity and Occupancy Rate, by Specialty, in the  
Bureau's Four Principal Referral Centers,  
Fourth Quarter FY 1988

	Number Beds				Occupancy Rates			
	MED	SURG	PSYCH	TOTAL	MED	SURG	PSYCH	TOTAL
Springfield	139	197	294	630	212%	81%	96%	117%
Rochester	80	20	74	174	94	84	72	83
Lexington	25	22	38	85	94	8	50	52
Butner	0	0	163	163	94	84	72	83

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SOURCE: BPSMed3 Forms.

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### Purchasing Services From Outside Providers

Bureau officials remark that the current health care system is already "privatized" to a significant extent because private providers are used frequently. Indeed, about 20 percent of all prisoners seen during outpatient visits are seen by non-BOP medical personnel.<sup>19</sup> (Some of these providers will be public officials working for other government departments. The available data sources classify them together with private sector providers as "outside" providers.) In addition, non-BOP facilities serve a large number of prisoners requiring inpatient care.

The heavy use of "outside" medical providers is reflected in the distribution of health care expenditures. Table 1.6 shows the amounts budgeted for services provided by BOP employees and those for services of outside providers during the Fiscal Years 1984 through 1989.

Table 1.6  
Total Budgets for Medical Services,  
with Totals for Services Directly Provided and  
Those Purchased, FY 1984-1989

<u>Year</u>	<u>Total Current Expenditure</u>	<u>Directly Provided (%)</u>	<u>Purchased (%)</u>
FY84	\$45,205,345	\$32,724,659 (72.4)	\$12,480,686 (27.6)
FY85	51,525,209	37,532,597 (72.8)	13,992,612 (27.2)
FY86	61,602,111	42,706,392 (69.3)	18,895,719 (30.7)
FY87	73,583,267	50,901,574 (69.2)	22,681,693 (30.8)
FY88	82,080,292	57,103,360 (69.6)	24,976,932 (30.4)
FY89	93,856,767	61,188,736 (65.2)	32,668,031 (34.8)

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NOTES: Total current expenditure is defined as budgeted cost of health care services (i.e., total "decision unit" (DU) B amounts, minus budgeted amounts for equipment). It represents, therefore, the cost of operations distinct from capital acquisition. "Total purchased" represents all charges to the BOP for services obtained from non-BOP providers. Data were not yet available for the 4th Qtr of 1989; amounts were extrapolated from data from other three quarters of that year.

SOURCES: Computed from data provided by the Bureau of Prisons.

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Between Fiscal Years 1984 and 1989, spending for purchased medical services grew 161 percent, from \$12.5 to \$32.7 million. During the same period, spending for

directly provided care increased less rapidly--87 percent, from \$45.2 to 93.9 million. The proportion of services bought has consequently been growing, from 28 percent of the total to 35 percent, during this five-year period.

These increases reflect increased spending for two different types of services: consultants coming into the prisons, and services purchased when the prisoners travel outside to local community hospitals and physicians. As shown in Table 1.7, the cost of services purchased from community hospitals rose from \$9.3 million in FY 1984 to \$23.3 five years later--an increase of 151 percent. The cost of consultants coming into the facilities increased even more rapidly, from almost \$3.0 to \$9.3 million during the same period, a 210 percent increase. Throughout this period, about three-quarters of all purchased services were for services provided in local hospitals rather than by consultants coming into the prisons.

Table 1.7

**Budgets for Outside Medical Services:  
Comparing Amounts for Services in Community Hospitals and  
Amounts Budgeted for Consultants Coming into  
Prisons or Referral Centers, FY 1984-1989**

<u>Year</u>	<u>Community Hospital Services</u>	<u>In-Prison Consultant Services</u>
FY84	\$9,513,290	\$2,967,396
FY85	10,162,427	3,830,185
FY86	14,043,556	4,852,163
FY87	16,397,298	6,284,395
FY88	17,339,308	7,637,624
FY89	23,287,824	9,380,207

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SOURCES: Bureau of Prisons data. Community hospital services identified as DUB25 costs; these include both outpatient consultations when the prisoner had to travel to the community hospital, as well as inpatient services. Existing data provide no way to distinguish between the two types of charges. In-prison consultant services identified by DUB50(250CN) codes.

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The rising cost of consultants coming into prison reflects inflationary increases in medical costs, a rising demand for services because of growing federal prisoner population, and also a shortage of BOP employees to provide the needed

services (discussed more fully below). Whereas 10 percent of the total cost of in-prison medical labor during Fiscal Year 1984 went to purchasing consultants' services, by Fiscal Year 1989 that proportion had risen to 17 percent.<sup>20</sup>

The increased spending for community hospitals also reflects inflation in medical costs and the increase in the numbers of federal prisoners under custody. In addition, it also may result in some measure from an inability of the referral centers to accept prisoners because of insufficient bed-space. In May of 1989, for example, only 76 percent of all requests for transfer to a referral center were accommodated. Although the data do not show what happened subsequently, some proportion of these prisoners were sent to community hospitals instead.<sup>21</sup>

### Summary

In summary, the principal strains on the current health care system appear to include:

- growing expenditures for health care,
- an increasing reliance on non-Bureau providers, the cost of which is inflating rapidly and is difficult to control,
- a rising demand for health care because of a growing federal prisoner population and an expanding proportion of older and sicker prisoners needing more services and more expensive treatments,
- the necessity of finding more beds in the system, either in Bureau or non-Bureau hospitals, or reconfiguring the current system more efficiently.

It is important, however, to place these cost-related strains in perspective. Despite an apparent increase in average expenditure per prisoner, when adjusted for inflation, the Bureau's per capita expenditure for health care has remained fairly stable over the past five years and has not grown at any faster rate than the Bureau's total budget.



## Endnotes

1. This classification of inmates is based on an objective assessment of their propensity for involvement in serious rule infractions, especially violence and escape. A higher security level rating represents a greater risk of involvement in serious misconduct. The percentages listed here reflect the proportion of inmates in each security level group. Ten percent of all inmates were not assigned a risk level. Data from Federal Bureau of Prisons, Research and Evaluation Unit, May 1990.
2. "Obligations by institution by decision unit for major medical institutions for fiscal year 1988," accounting run provided by the Bureau of Prisons. "Health care services" are defined as decision unit B costs. Included in these figures are purchases of equipment.
3. See Chapter Two for estimates of expenditures for inpatient and outpatient costs.
4. "Fact Sheet: U.S. Medical Center for Federal Prisoners," undated.
5. "Obligations by institution by decision unit for major medical institutions for fiscal year 1988," accounting run provided by the Bureau of Prisons. This includes purchases of equipment.
6. "Obligations by institution by decision unit for major medical institutions for fiscal year 1988," accounting run provided by the Bureau of Prisons. This includes purchases of equipment.
7. Because Rochester makes a distinction between inpatients and outpatients among those held at the referral centers, and because all other referral centers call them all inpatients, these daily census figures may not be comparable.
8. "Obligations by institution by decision unit for major medical institutions for fiscal year 1988," accounting run provided by the Bureau of Prisons. This includes purchases of equipment.
9. "Bureau of Prisons Obligations and Per Capita FY 88, as of 9/30/88," provided by Jim Jones. Because these figures are from an earlier accounting run than those shown the facilities described above, they may not reflect a final tally of expenditures.
10. Ibid.
11. "Total Medical Obligations by year 1984 through 89, as of June 27, 1989," provided by the Bureau of Prisons. This amount includes expected purchases of equipment.
12. Provided by Rhonda Ward, PHS/Bureau of Prisons.
13. Computed from "Bureau of Prisons Obligations and Per Capita FY 1988, as of 9/30/89." The cost of central office health care operations (\$8,054) was excluded in order to show more clearly the distribution of costs among prison facilities.
14. For a discussion of drug law prosecution and sentencing practices, see "Drug Law Violators, 1980-86," Bureau of Justice Statistics Special Report, (Washington,

- D.C.: June 1988). For a discussion of the impact of the drug law and the sentencing guidelines, see United States Sentencing Commission, Supplementary Report on the Initial Sentencing Guidelines and Policy Statements (Washington, D.C.: June 18, 1987), Chapter 7.
15. "Projecting the Bureau of Prisons Population Through 1995," (Washington, D.C.: Bureau of Prisons, Office of Research and Evaluation, May 1989).
  16. "Looking Ahead -- The Future BOP Population and Their Costly Health Care Needs," Research Bulletin, Office of Research and Evaluation, Federal Bureau of Prisons, (Washington, D.C.: January 1989). According to the American Correctional Association, "inmates aged 55 or older made up more than 3 percent (18,800) of the total population (597,000) of federal and state prisons" in 1988. By the year 2000, Professor Chaneles of Rutgers has estimated there will be about 125,000 inmates over age 50 of whom 50,000 will be older than 65. See Criminal Justice Newsletter, November 15, 1989, p. 5.
  17. Ibid. Again, note that this estimate does not account for the additional aging of the prisoner population that will result from longer imposed sentences.
  18. Memorandum from Steve Dann, Bureau of Prisons Health Services Division, to Dave Sweda, dated 13 June 1989.
  19. Computed from Table 1.1 above.
  20. Computed from Bureau of Prisons budget data. The total cost of direct labor provision for medical services includes here the salaries and benefits of those medical personnel charged under decision unit B, minus the overtime charges by correctional officers that were charged to medical purposes. Consultant charges were identified by DUB50(250CN) codes.
  21. Cited in a memorandum from Steve Dann to Dave Sweda, June 13, 1989.

## CHAPTER TWO

DO THE REFERRAL CENTERS PRESENT  
OPPORTUNITIES FOR COST CUTTING?

To assess the odds of whether the private sector will be able to improve the efficiency of any or all of the referral centers, and thereby lower their costs, it is helpful to understand what services at these centers now cost. It is also useful to know what factors determine these costs and how easily changed these factors appear to be. This information strengthens our ability to assess whether various forms of privatization are likely to reap lower costs, and whether such results might be obtained by other means as well.

To assess the size and nature of the cost-cutting opportunities at the four largest referral centers (Rochester, Springfield, Lexington, and Butner), budget data were obtained and examined. (Budget data rather than expenditure data were used in these analyses, although we refer to "expenditures" or "spending." Budgeted dollars are therefore used as proxies for expenditures in the following pages.) These data are far from perfect, limiting the ability to make comparisons across sites and with the free community hospitals. Nevertheless, they do suggest that the per diem hospital costs are already quite low, that patients' lengths of stay are long, and that little or no potential exists for savings by internalizing out-referrals to free community hospitals.

Table 2.1 estimates the average expenditure per patient admitted to each of the referral centers during fiscal year 1988, counting only the medical and surgical patients in all but Butner, and psychiatric cases only in Butner. Psychiatric cases are excluded from Springfield, Rochester, and Lexington because their stays are quite prolonged, on average, and present a different demand for treatment than do medical and surgical patients. As indicated in the earlier section, Butner's patients are admitted only for psychiatric reasons, which is why the average length of stay there is so long.

Table 2.1

Average Length of Stay and Total Estimated Cost per  
In-Patient Admission, by Referral Center, FY 1988

	Average Length of Stay (Days)	Estimated Average Total Cost
Springfield: (med/surg)	129.3	\$11,831
Rochester: (med/surg)	48.9	10,084
Butner: (psychiatric)	145.6	9,391
Lexington: (med/surg)	61.5	15,236

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NOTE: Rochester referral center estimates are weak because of different procedures used there for counting patients. For all, cost is computed by multiplying average daily expenditure for all patients in the referral center by average length of stay. Psychiatric patients in all but Butner excluded.

SOURCES: Length of stay computed from BPMED3 and BPMED12 reports. (See Table 2.2 below for estimates of average daily cost.)

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It is important to understand what these estimates do and do not represent:

- They include costs of all medical care to inpatients, whether provided inside the facilities by government employees, by consultants coming into the facility, or by non-Bureau providers in local community hospitals beyond the prison walls. These "outside" costs are included because the services they purchased were intrinsic elements of the treatment of patients referred to the prison hospitals for care, and because the existing accounting system does not permit distinguishing the amounts spent for inpatient care in local community hospitals from care by outside providers to referral center inpatients.

- They do not include any costs of the capital assets used, unlike charges from outside hospitals. No data are available that can be used to value current assets.

- These estimates were drawn from reports that are submitted to the central headquarters from the referral centers, and there appear to be inconsistent rules for reporting patient counts from one facility to the next. The daily costs for Rochester

are probably overestimated because officials there do not count in their tallies of hospitalized patients persons they label "outpatients" even though they are hospital patients rather than general population prisoners.<sup>1</sup>

- Estimates of expenditures for outpatient clinic services to inmates in the general population are excluded. (See Table B.2 in Appendix B for a discussion of how these expenditures were estimated.)

- Because expenditure data are not available for individual patients, or for types of cases, the estimates for medical/surgical patients in the Springfield, Lexington, and Rochester centers do not represent actual averages for only medical/surgical patients. These data were computed by estimating the average daily expenditure for all patients in each referral center and then multiplying this average by the average length of stay for only medical/surgical patients. Because psychiatric treatment is probably less expensive on a per diem basis, the actual cost of medical/surgical treatment is probably higher than the estimates shown here.

The variations in total cost per inpatient admission result from differences in average daily cost per patient and the average length of stay in the referral center, discussed below.

These expenditures are substantially higher than the national averages for admitted patients. During 1988, according to the American Hospital Association's annual survey, the average expenditure by non-federal short-term general hospitals was \$4,194 per admission.<sup>2</sup> If one excludes 11 percent of this amount as the share of the expense that represents the approximate cost of capital—because the expenditures at the referral centers for capital spending have been excluded--the adjusted national average was \$3733 per admission.<sup>3</sup>

Current costs of non-correctional psychiatric hospitals are not available but can be loosely estimated from 1981 data. In that year, the average cost per day in a private psychiatric hospital was \$78. The average stay was 19 days, which resulted in an average cost per admission of \$1,482.<sup>4</sup> Assuming (1) that the cost of services in psychiatric hospitals rose at the same rates as medical services generally, (2) that capital costs were an estimated 11 percent, (3) that the average length of stay remained unchanged from 1981 to 1988, we estimate that the average cost per admission to a private psychiatric hospital during 1988 would have been approximately \$2,203. This compares to approximately \$9,391 at Butner.

These per-admission costs vary so greatly because hospitalization in prison is very different in practice than hospitalization in the free community. Hospitals in the free community do not have heavy security and all the attendant costs. The estimates for the referral centers do, in contrast, include a share of the overall prison's expenditures for security. (See below for an estimate of that share.) There may also be differences in the mix of cases in each class of hospital.

Length of stay is also much longer in prison hospitals. Whereas the national average length of stay for medical/surgical patients in non-federal short-term community hospitals was 7.2 days during 1988, average stays for medical/surgical patients ranged from 49 days in Rochester to 129 days in Springfield.<sup>5</sup> People needing hospitalization in the free community are able to complete many of the early processing stages on an outpatient basis, prior to admission. This includes diagnostic testing, filling out needed records, preoperative evaluations, and the like. These steps are taken after a prisoner is received at a referral center, which consumes bedspace that would often not be incurred were the patient not a prisoner. Similarly, prisoners are not permitted to go home shortly after medical treatment or surgery to convalesce. The only current alternative to patient status in federal prisons is "general population" status, in which one has to be able to fend for oneself. Moreover, life in prisons makes it difficult to move about in wheelchairs and crutches.

Because prisoners discharged from referral centers are transferred to other prisons, the lack of space in these other prisons makes rapid discharge difficult. The Bureau's facilities currently have no slack in bedspaces due to crowding, especially in the high-security facilities. When a prisoner is transferred to a referral center, his or her bed is given immediately to someone else, and wardens are reportedly reluctant to accept the prisoner upon discharge. Finding a bed in the system for the prisoner takes time, which stretches out the patients' stay still longer.<sup>6</sup>

### Estimating the Daily Cost of Hospitalization

Because comparisons of per admission expenditures are complicated by these structural differences in hospitalization in the prison and free community settings, comparisons of per diem expenditures provide additional information that is revealing. Table 2.2 shows the estimated costs of inpatient care in each of the four major referral centers for all types of patients combined. (These computations count the same costs and exclude the same as do the computations shown in Table 2.1.)

Table 2.2

Estimated Average Daily Cost of Hospitalization  
in Four Referral Centers, FY 1988

Springfield	\$91.50
Rochester	206.22
Butner	64.50
Lexington	247.70

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SOURCES: Computed from various data provided by the Bureau of Prisons. See Table B.1 in Appendix B for the complete calculations of revised estimates.

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These figures are substantially higher than the ones used by the Bureau. The Bureau's method of calculation underestimates expenditures for hospitalization in the referral centers by computing an average per capita expenditure for imprisoning all inmates, both those admitted for hospitalization and those in the prison's general population. To estimate more accurately the expenditure for inpatient care in each of the four major hospitals during Fiscal Year 1988, we isolated spending for health care (called "medical" in the Bureau's accounting systems) and then allocated a portion of all other facility expenses as well. This is because the cost of treating inpatient prisoners should include expenditures for feeding and supervising them, maintaining the physical plant, and some proportion of overall administrative and other support services. (See Table B.1 in Appendix B for more detail on this estimation.)

The costs shown in Table 2.2 are substantially lower than costs in free community hospitals. During 1988, the national average daily expenditure for hospitalization in non-federal short-term community hospitals was \$581.<sup>7</sup> Adjusting for the approximate share of this cost that represents spending for capital, the daily average was \$523, compared to \$65 to \$248 in the four referral centers.<sup>8</sup>

A better comparison of hospital-related expenses excludes the cost of providing security to prisoners (although this is biased also by the large differences in the lengths of stay.)<sup>9</sup> Table 2.3 estimates the share of the average per diem

expenditures devoted to medical labor, to prisoner security, and to all other hospital functions.

Table 2.3

Estimated Average Daily Expenditures for Hospitalization  
in Referral Centers by Type of Expense, FY 1988

	<u>Medical</u>	<u>Security</u>	<u>Hospital</u>	<u>Total Average Daily Exp.</u>
Butner	\$32.45	\$11.13	\$20.91	\$64.50
Lexington	\$183.55	\$8.36	\$55.79	\$247.70
Rochester	\$140.54	\$14.58	\$51.09	\$206.22
Springfield	\$41.23	\$18.31	\$31.96	\$91.50

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NOTE: Includes the all expenditures for services provided when inmates travel to outside community hospitals (counted here as "hospital" costs, even though charges by physicians seen outside are also included). Excludes expenditures for outpatient care to general population inmates.

SOURCES: Computed from data provided by Bureau of Prisons. See Table B.4 in Appendix B for full documentation.

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Excluding the estimated per diem expenditures for prisoner security lowers the average daily cost of hospitalization still further, to \$54 at Butner, \$239 at Lexington, \$192 at Rochester, and \$73 at Springfield. These per diem costs are quite low, compared to general community hospitals. Although it is risky to draw inferences from such comparisons for several reasons (lack of information about differences or similarities in mixes of cases, unstandardized accounting of costs, etc.), the general point remains that the costs of providing hospitalization services in the referral centers appears to be much below the cost of hospitals in both the private and public non-correctional sectors.

The wide differences among the four referral centers in per diem expenditures may suggest at first glance that savings might be obtained by bringing costs in the more expensive centers closer to those in the less expensive centers. Further analysis indicates that these variations derive from different structural features of each referral center, and are not easily changed.



The variation in per diem expenditures for inpatients at each referral center is explained partly by differential use of non-Bureau health care providers. Referral centers vary in the extent to which they rely on consultant physicians coming into the prisons, and on outside hospitals for diagnoses, outpatient treatment, and inpatient hospitalization. Table 2.4 shows how much was spent during FY88 for in-prison consultation and outside-prison services, expressed both as a total expenditure and a per capita daily expenditure. (These per capita expenditures represent the average expenditure for such services for all patients admitted to the referral centers, whether they received services from these providers or not.)

Table 2.4

Expenditures for Services Provided by Non-Bureau Providers to Inpatients and Outpatients, Distinguishing Delivery Outside and Inside the Facilities, Per Patient/Day by Referral Center, FY 1988

	<u>Delivered Outside</u>		<u>Delivered Inside</u>	
	<u>Total Exp.</u>	<u>Per Day</u>	<u>Total Exp.</u>	<u>Per Day</u>
Springfield	\$1,781,682	\$6.91	\$2,691,435	10.43
Rochester	6,449	0.15	2,275,611	51.56
Butner	229,230	4.04	674,245	11.88
Lexington	2,212,873	90.37	2,607,983	106.50

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NOTE: Total expenditures are divided by total number of patient/days, both inside and outside days combined.

SOURCES: Computed from data provided by the Bureau of Prisons. "Outside delivery" expenditures are identified as DU B25 expenditures in Bureau accounts; inside consultants as DU B50/250CN. See Table B.3 in Appendix B for full computation.

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The high expenditure for health care at the women's referral center in Lexington reflects the heavy use of outside consultants coming into the facility as well as nearby hospitals. Indeed, \$197 of the total \$291 average per capita expenditure is spent for services by non-Bureau providers. Much of this spending seems difficult to avoid. The Bureau has not been able to recruit a full-time physician specializing in obstetrics/gynecology, or a dermatologist, and consultants are used instead. Because of

the relatively small patient population at Lexington, and the resulting low demand for special services, it is not economical to hire a full-time orthopedist, cardiologist, urologist, or radiologist, among others. Bureau officials also report that many of these consultants charge rates that are generally higher than the cost to the Bureau of government-employed physicians, often in the \$150-300,000 per annum range.<sup>10</sup> This pushes up the average.

Spending for services outside the prison also are difficult to avoid for other reasons. Women are taken to local hospitals for birthing their babies, as they are for all but the most routine "lumps and bumps" surgery. The facility at Lexington is old and not capable of supporting more complicated in-house surgery, and the referral center is not staffed with the round-the-clock physicians, labs, blood banks, and other professionals that would be needed. More extensive use of local community hospitals increases the average cost per treatment (expressed either in per diem or per admission terms), because treatment in these local hospitals is more costly, on average, than treatment in the referral center. Table 2.5 shows the average cost per day of hospitalization in the local community hospitals near each of the four major referral centers during fiscal year 1988.

Table 2.5  
Estimated Average Daily Expenditure for Hospitalization  
in Referral Centers (Including Outside Costs) and  
In Nearby Community Hospitals, FY 1988

	<u>Referral Centers</u>	<u>Nearby Hospitals</u>
Springfield	\$91.50	\$1,372.70
Rochester	206.22	2,178.90
Butner	64.50	1,502.20
Lexington	247.70	1,352.30

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NOTE: Referral center costs include no estimate for capital, whereas nearby hospital costs include a capital component.

SOURCES: Computed from various data provided by the Bureau of Prisons in BPMed12 reports.

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As Table 1.2 in Chapter 1 shows, Lexington had an average of five women prisoners in local community hospitals on any given day during fiscal year 1988, compared to two at Springfield, two at Rochester, and none at Butner. This utilization of local hospitals, in combination with their higher costs, explains in substantial detail why Lexington's per diem average expenditure for care is higher than the other centers.

Outside hospital costs are higher in part because the Bureau of Prisons has to transport prisoners under guard to the hospital as well as guard them there. Maximum-security inmates require several officers on guard around the clock, and others must follow the transport vehicle in a "chase car" while being moved to and from the hospital. Lower security prisoners are guarded somewhat less intensively, but still must have round-the-clock coverage. Bureau employees on these duties generally work entirely on overtime, drawing a high hourly wage. Some referral centers use contract security officers ("rent-a-cops") for low-security inmates. Because there is a lack of standardization in reporting correctional officer costs associated with inpatient stays in community hospitals, it is difficult to determine precisely what the daily costs of outside hospitalization are. We have estimated these costs using data provided by the Bureau, which are shown in Table 2.6. This table also shows how expenditures for outside hospitalization are distributed among medical labor, security, and all other hospital costs.

Table 2.6

Average Daily Cost of Hospitalization in  
Nearby Community Hospitals by Type of Expense, FY 1988

	<u>Medical</u>	<u>Hospital</u>	<u>Guarding</u>	<u>Total Average Daily Cost</u>
Springfield	\$181.30	\$496.80	\$694.70	\$1,372.70
Rochester	525.10	959.10	694.70	2,178.90
Butner	151.90	655.70	694.70	1,502.20
Lexington	174.40	483.30	694.70	1,352.30

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NOTES: Medical and hospital charges are taken directly from Bureau reports. Because of apparent inconsistencies in the reporting of correctional officer costs ("guarding"), we have assumed here that figures reported by Springfield approximate the actual cost in all referral centers, and we use those figures.

SOURCES: Computed from various data provided by the Bureau of Prisons in BP MED3 and BP MED12 reports.

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Variations in per diem costs at the referral centers also result from differential use of outside hospitals for diagnostic testing. In smaller centers, such as Lexington, where demand is low, it is not economical to purchase expensive diagnostic equipment. Prisoners are therefore taken to hospitals under guard, at a higher cost, for outpatient diagnostic services. By consolidating patients, it sometimes becomes economical to purchase certain diagnostic equipment for in-house use. For example, when Lexington was converted from a mixed to all-women's facility, the demand for mammography exams increased sufficiently to warrant purchasing the necessary equipment. The center administered 600 mammograms the first year, and at the 800 point, the equipment paid for itself. Whether or not it is possible to "make" still other types of services rather than "buy" them outside was not determined.

At Rochester, the expenditures for in-prison consultants reflects the heavy use of Mayo Clinic physicians. Because the physical plant at Rochester is more modern than Lexington's, the staff there is able to perform all but the most complicated

surgeries in the referral center. (This also explains, in part at least, the high average daily expenditures for outside hospitalization in Rochester, shown in Table 2.5.) This reduces substantially the reliance upon outside services in local hospitals. The remaining expenditures for "inside" health care are still substantially higher at Rochester than at other facilities, however (\$166 versus \$75 at Springfield, \$59 at Butner, and \$94 at Lexington). This may reflect the fact that Rochester was able to staff fully its higher-level professional positions because of the advantageous labor pool near the Mayo Clinic, and perhaps due to a higher ratio of staff to patients during FY88, which has changed in recent months with an increase in average daily patient cases.

Finally, Butner's low expenditure reflects the patient mix there: all prisoners in the referral center are psychiatric patients. Prisoners needing medical or surgical care are either seen by consultants coming into the facility, or are sent to an outside hospital, or to one of the two other referral centers (Rochester or Springfield).

#### How Easily Changed Are the Determinants of Referral Centers' Costs?

The low per diem cost of hospitalization in the referral centers does not signal obvious opportunities for contract management firms to make significant cost-savings. One must be careful to draw conclusions of this sort, however, because one cannot make easy inferences about relative efficiency when comparing the referral per diem costs among referral centers, or among the referral centers and hospitals in the free community. Because the lengths of stay in the referral centers are so radically different from those found in community hospitals, per diem comparisons are distorted. (The long stays in the referral centers for waiting and convalescence drive down the per diem averages, compared to local hospitals, where in-hospital treatment is concentrated into fewer days.) With these caveats in mind, this section examines the potentials for savings in each of the functional areas in the referral centers (security, clinical/medical, and other hospital operations), as well as the possibilities of increasing productivity in them.

#### Spending for Security

There are no obvious reasons to think that spending for security staff in these centers will be reduced by contracting for either the management or the operation of the clinical functions. Indeed, it is possible that security costs will increase if anything more than management of the clinical functions is contracted. As discussed

below in Chapter Three, all health care workers currently employed by the Bureau supervise inmates assigned to work details in the referral centers, exercise a number of custodial duties, and are expected to respond to "custodial emergencies," such as fights, escapes, riots, etc. In addition, they are permitted walk unescorted throughout the prison and to carry keys. Consultants and contractors, on the other hand, are not given such broad responsibilities. According to the Chief of Operations for the Medical Services Division, the use of outside contractors actually induces inefficiencies, because Bureau-employed PAs are required to escort consulting physicians, carrying keys for them, and locking and unlocking doors and files.<sup>11</sup>

Dr. B. Jaye Anno, who reviewed an earlier version of this report, remarked that this argument is "specious." The likelihood that security staff costs will rise upon contracting for clinical staff rests on the assumption that current policies regarding contractors' privileges and duties are unchanged. If contractors' privileges are broadened to encompass those now held by BOP employees, there would be no reason to expect higher spending for security staff.

To get some estimate of the additional expenditure that might be required for security services in a referral center if all clinical services were contracted to a private firm, the administration at the Lexington center was asked to determine how many additional posts for correctional officers would have to be created at the center. They were asked to assume that the policies regarding carrying keys could be relaxed, but no changes in policies regarding inmate supervision and escort. They estimated that an additional twenty-six authorized positions would be required, twenty-three of which would be at the GS-7 level, and three at the GS-11 level. The latter three include a training lieutenant to cover the training of all employees, and a hospital lieutenant to monitor staff, count needles and syringes, and for other custodial responsibilities. The costs of these additional posts would be substantial. The middle of the GS-7 range currently pays a salary of \$22,100 per full-time equivalent; the middle of the GS-11 range pays \$32,700 (both salaries exclude benefits). The administrators suggested also that the use of outside hospital facilities might also increase because a contractor's concern for protecting itself against liability, which would create an additional demand for correctional officer escorts.<sup>12</sup>

#### Clinical Staff Costs

As Table 2.3 shows, average per diem expenditures for medical labor in the referral centers was quite low in FY 1988—between \$32 per day at Butner and \$184 at

Lexington, which includes any expenditure for consulting physicians coming into the centers. This was substantially lower than in community hospitals. In 1988, the national average was \$307.61, which included spending for all categories of labor, not just clinical staff.<sup>13</sup> This was also lower than the charges for medical staff services for inpatient treatment in the community hospitals used by the referral centers. Table 2.6 shows that medical labor charges in those hospitals ranged between an average of \$152/per inpatient day (near Butner) to \$525 (near Rochester) during FY 1988.

Contractors would have to pay medical staff higher wages than the Bureau currently pays, or they would more than likely suffer the same recruiting and retention problems that the Bureau faces. Medical labor costs would therefore increase, pushing up the per diem expenditure of hospitalization in the referral centers correspondingly, unless there were changes in the way the centers were staffed.

One obvious strategy for reducing labor costs would be to make more extensive use of lower-paid physicians' assistants in lieu of physicians, and licensed practical nurses in place of registered nurses for many duties. Our review of staffing shows, however, that the Bureau's referral centers already make heavy use of PAs and LPNs, and no evidence was found that any of the referral centers are too richly staffed with expensive personnel. Indeed, the opposite is true: most of the centers are currently understaffed, which contributes to the low per diem expenditures for hospitalization.

If the referral centers were fully-staffed, and if these staff were compensated at currently-permitted levels, spending for medical labor in Bureau-managed centers would be substantially higher, although this would be offset by saving an undetermined amount that is currently spent for consulting physicians who are used to fill gaps created by staff vacancies. If compensation were raised to market levels, the additional expenditure would be still higher if the centers were fully staffed. Unless contract management firms could hire doctors at below-market rates, it does not seem possible that those firms would create savings in labor costs.

#### **Other Hospital Costs**

Spending for all other costs associated with the referral centers is very low, as Table 2.3 shows. During FY 1988, those expenditures averaged, on a per diem basis, between \$21 at Butner to \$56 at Lexington. (The differences among referral centers resulted in part from the inclusion of charges for treatment outside the facility, in local hospitals. This explains why Lexington's average expenditure was higher than the

others.) These costs are lower than the community hospitals'. As Table 2.6 shows, the hospitals near the referral centers spent an average of \$483 to \$959 per day during FY 1988 for all functions other than medical personnel services. The referral centers reap an enormous benefit from the large pool of nearly free labor that prisoners provide. A contract management or services firm would probably be able to continue using the services of the prisoners if it assumed control of clinical duties in a referral center, which would keep these costs down. A firm might also be able to bring some other costs down, but the already-low levels suggests that there may be relatively little opportunity for making dramatic savings in this category of expense.

### Increasing Productivity

When the expenditure for hospitalization in the referral centers is computed on a per admission basis, different cost-cutting possibilities are suggested. If length of stay were shortened, the average cost per treatment would be reduced if new patients were admitted to the referral centers as soon as other patients were transferred back to other prisons. If beds were not filled quickly, and shortened stays resulted in a drop in occupancy level, few savings would be generated because most of the costs of operating a referral center are fixed. (The cost per admission would simply rise, proportionately.) If increasing the speed with which the centers process patients reduces the use of outside hospitalization that is induced by a lack of space in the centers, savings would be obtained.

If length of stay remains at the same high levels, and additional hospital space is acquired to accommodate the demand that will exist once the four major referral centers become fully occupied (which is likely to occur within a few months), the average cost per treatment will remain approximately the same in these four referral centers. Rather than speeding up patient processing and making room for the coming increases in demand, that demand will be shifted onto another center, with all the fixed costs associated with it.

This raises questions of how easily changed the length of stay is in the referral centers, and whether contract management firms are likely to be able to reduce them.

### Causes of Long Stays

As discussed earlier in this chapter, stays in prison hospitals are longer than in community hospitals in part because of the prisoners' inability to live at home while being prepared for hospitalization and while convalescing afterwards. There are other



reasons as well. The need to find a bed in another prison after discharge becomes more difficult when such beds are in short supply, and patients who are well continue to sit in the referral center while their transfer is being arranged. The actual transfer itself also requires waiting. Prisoners are not simply told to check out of the referral center when they are well, but must await a federal correctional transport bus or plane to pick them up. To make such transportation economical, the referral centers wait until groups of prisoners are ready, rather than taking them one by one as soon as they are ready. The long lengths of stay in the centers result, therefore, from system-wide structural constraints that are not within the power of the referral centers' managers to affect. Contract management firms would probably fare no better at getting the system to respond more quickly.

In addition, it appears that delays also result from understaffing. Being processed in one of the referral centers involves having a number of tasks accomplished by a variety of different staff. At each stop in the process, prisoners wait in a queue for services. The length of that queue depends upon how many staff persons there are at each stop, as well as how many patients need the service. Upon admission, clerks have to take information from prisoners and their records for the centers' records. Prisoners receive physical examinations, lab tests, and surgical procedures. If the physician in the referral center determines that a consultation with a specialist is needed, the prisoner either awaits the day that the specialist routinely comes to the facility or goes outside to a local hospital. If the prisoner waits for the routinely scheduled visit, there may be a backlog, requiring a few weeks to see the specialist. If the specialist requests diagnostic tests, those tests have to be scheduled, and then the prisoner must await yet another visit from the consultant to have the results interpreted. If the prisoner is to be taken outside the facility to a local hospital for a consultation, or for diagnostic testing, there is a queue for such visits because correctional officers are needed for escorts. If staff are in short supply at any stage, the queues and the waiting times between services are lengthened. At present, there is a shortage even of clerical staff in the centers, which creates a fifteen to eighteen day delay at Springfield, for example.<sup>14</sup>

A comparison of staffing ratios and length of stay at Rochester provide some indirect support to the argument that length of stay and staff/prisoner ratios are correlated with one another. Table 2.7 shows the census of medical and surgical patients at the beginning of each month, from October 1987 through November 1988; the number of Bureau-employed medical staff per each patient; and the average length

of stay of all those persons discharged during the month. (Unfortunately, this does not reveal the numbers of consulting physicians who came into the facilities to provide services; the ratio of staff to prisoners is therefore underestimated by some undetermined amount.) In October and November of 1987, the number of patients in the referral center was in the low 40s, and there were two medical staff to each patient. The average length of stay of all patients discharged in those months (and in the month following) was short--between 17 and 40 days. There was a large influx of patients in November 1988, more than doubling the population. By February, the census at the beginning of the month had tripled the October/November numbers, the numbers of prisoners reached a plateau in the 120-130 range. During this period, the ratio of staff to prisoners also dropped. (The referral center started this period with a substantial number of vacancies but filled them in progressive fashion throughout the fourteen months shown here.) With the influx of new patients in November 1987, the ratio dropped from more than two staff per one patient to slightly less than one per patient. The effect of the doubling and tripling of the prisoner population began to show up in lengthening stays for those discharged in the winter months of 1988. By June of 1988, the average length of stay had tripled the October 1987 rates--126, on average.

Table 2.7

Relationship Between Numbers of Medical/Surgical Patients and  
Average Length of Stay: Rochester

	Census at Beginning of Month	Number of Medical Staff per Patient	Average Length of Stay (Days)
October 1987	41	2.10	40
November	42	2.12	31
December	102	0.91	17
January 1988	124	0.77	50
February	119	0.82	76
March	118	0.86	73
April	108	0.95	65
May	123	0.89	105
June	129	0.90	126
July	130	0.89	147
August	132	0.89	127
September	121	0.91	124
October	90	1.30	126
November	112	1.08	96

Note: Average length of stay defined as average days in referral center for all persons discharged during month.

Source: Memorandum from Brenda Timm to Dr. Grogan, Federal Medical Center at Rochester, January 20, 1989, and telephone interview with Brenda Timm, December 1989; staff data computed from BPMEDI8 reports.

A longer data series would be more revealing, as would comparisons with other institutions, but the data in Table 2.7 generally supports the contention of Bureau officials that an increase in numbers of staff would cut patient stays. The Chief of Operations for the Medical Services Division estimates that if the referral centers were all fully staffed, the length of stay could be reduced by 30 to 50%. If all bottlenecks in the system were cleared—including the constraints imposed by transportation problems and overcrowding in the Bureau's prisons—he estimated that the average length of stay would be no more than 20 days, on average.<sup>15</sup>

Stays for psychiatric cases are more inflexible. There are three categories of such cases in the referral centers: commitments for observation, chronic, and acute cases. Prisoners in the first category are committed to the Bureau by the federal courts for observation, and these are required by law to stay at least 35 to 50 days. Chronic cases stay in the centers for long periods of time because they are unable to be moved back into the general population, not because of queues in needed services but because of their disabilities. Acute cases may be able to be moved through the hospitals more quickly, but like chronic cases, the speed of their recuperation is not influenced strongly by the type and speediness of treatment.

Finally, the ability to reduce spending by shortening the length of stay is offset to a degree by the fact that prisoners discharged do not stop costing the Bureau money. All prisoners go back to general population in various facilities, and during the FY 1988, the average per diem expenditure for imprisonment in the Bureau was estimated at \$42 per prisoner. The potential savings therefore range, on average, between \$34 and \$249 per day, depending upon the referral center from which prisoners are discharged.

### Summary

Although the quality of the available data do not permit a powerful and sophisticated analysis of service delivery costs and their determinants, the analysis presented here suggests the following:

- The average daily cost of inpatient treatment at the four major referral centers is quite low (between \$65 and \$248 during FY 1988), and substantially lower than the national average daily cost for hospitalization in the free community (\$523 during the same year). This comparison is somewhat misleading, however, given the longer lengths of stay in the Bureau's centers, which reduces the average daily cost in them.
- Because of the longer lengths of stay, the average cost per admission in the four major referral centers during FY 1988 was higher than in the free community hospitals: between \$9,291 and \$15,236 for the referral centers, compared to the national average of \$3,733 in community hospitals that year. (Hospital stays averaged between 49 and 129 days in the referral centers, compared to the national average of 7.2 days in community hospitals.)
- The comparatively low average daily cost of hospitalization in the referral centers result in part from the lower wages paid to staff and to understaffing.

- Alleviating the understaffing will probably result in higher labor costs, and in higher per diem costs of hospitalization.
- Security costs associated with guarding the referral centers will probably not be reduced by contracting for clinical and/or management services, and may even be increased somewhat.
- The remaining costs associated with hospitalization (supplies, food, housekeeping, etc.) are very low, which suggests little room for significant cost-reduction.
- The single obvious opportunity for reducing costs is to shorten patients' length of stay in the centers. This may occur as understaffing is alleviated. Other possibilities for shortening stays by increasing hospital capacity, and for creating step-down convalescent care units, are discussed below.

## Endnotes

1. That is, the Rochester administrators distinguish between hospital inpatients, hospital outpatients, and outpatients in the general population. Other referral centers visited to do not distinguish between the first two categories and consider them all inpatients.
2. American Hospital Association, Hospital Statistics (Chicago: American Hospital Association, 1989), Table 1.
3. Killard W. Adamache, Trends in Capital Costs Under Prospective Reimbursement (Cambridge, MA: Health Economics Research, Inc., October 19, 1988), pp. 2-6, Table 3. This figure is for FY 1986, the most recent available. This represents depreciation and interest expenses for all buildings, fixed and moveable equipment.
4. Carl Taube and Sally Barrett (eds.), Mental Health, United States, 1985 (Washington, D.C.: National Institute of Mental Health, 1985).
5. National data from American Hospital Association, Hospital Statistics; Rochester and Springfield figures computed from data provided by the Bureau of Prisons.
6. Steve Dann, August 1989 interview.
7. American Hospital Association, Hospital Statistics, Table 1.
8. See note 3 for source of estimate for capital spending.
9. Because the length of stay in free community hospitals is so much shorter, patients in these hospitals get more intensive treatment and care during a single day, on average, than do referral center patients. This undoubtedly accounts for some portion of the difference in per diem costs between free community and Bureau hospitals.
10. Interviews with Steve Dann, August 1989; Jeanne Smith, Health Services Administrator, Rochester, November 1989; Michael Lynch, Assistant Health Services Administrator, Lexington, October 1989; and Captain Paul Goodspeed, Health Services Administrator, Springfield, October 1989. No attempt was made to collect systematic information on consultant's charges or rates.
11. Steve Dann interview, August 1989.
12. Communication from Michael Lynch, November 1989.
13. American Hospital Association, Hospital Statistics, Table 1.
14. Steve Dann interview, August 1989.
15. Ibid.

## CHAPTER THREE

## THE FEASIBILITY OF IMPLEMENTING A PRIVATELY-MANAGED OR OPERATED HOSPITAL WITHIN THE BUREAU OF PRISONS

How feasible it is to implement a privatization initiative depends in part on the scope of what is to be considered for contracting. In the referral centers, six principal options exist:

1. Transferring ownership, and contracting for management and operation of a referral center. This is the most comprehensive possibility.
2. Retaining public ownership, but contracting for the management and operation of all functions, including clinical responsibilities, security, food, and "housekeeping," among others.
3. Contracting for the management and operation of only clinical services in a government-owned facility.
4. Contracting for the management only of the entire clinical staff, again in a government-owned facility.
5. Contracting for top management of the clinical staff and the management and operation of one or more departments (e.g., pharmacy, laboratory, etc.) in a government-owned facility.
6. Management and operation of specific departments only in a government-owned facility.

The first two options--contracting for the ownership, management, and operation of all functions within a referral center, with or without transferring ownership to private entities--are the least feasible. No private firms provide all the services demanded. Firms do exist to operate private prisons, and others to administer hospitals, but none yet do both.<sup>1</sup> Two firms could team up, but there is little economic incentive to do so, because there is almost no market for administering prison hospitals.<sup>2</sup> (There are only a few such prison hospitals in the country, as discussed below.) More importantly, the absence of a competitive market makes the odds of becoming dependent upon a single partnership between two firms too high. (Transferring ownership in such a market environment is especially dangerous.)

Finally, contracting for the operation of an entire referral center makes little economic sense to the Bureau because these centers are parts of larger prisons (although the Springfield center comes closest to being nearly all hospital). Because

they are but parts of the larger organization, almost all of the referral centers' services are shared by the larger prison--including security, food, housekeeping, maintenance, and so forth. To have a private firm provide these services in the referral center, while the government provides the same services to the broader prisoner population, makes no sense economically.

The real choice, then, is between the latter four options. Whether it is most feasible to contract for the management, or the management and operation, of all or part of a referral center, depends upon several considerations. What follows in this chapter is a discussion of several issues relevant to the implementation of each of the four options. Subsequent chapters address considerations of cost and the effects of contracting on the delivery of health care services.

#### **Are Private Firms Available and Interested in Managing or Operating a Prison Hospital?**

Options (2) through (5) involve contracting for the top management of a referral center, in combination with different degrees of operational responsibility. At present, only one private firm has any experience either managing or operating hospitals located in correctional facilities, and this experience has been brief. In the summer of 1989, the Georgia Department of Corrections converted a 135-bed infirmary located on the site of a 600-bed prison into a hospital, now called the Augusta Correctional and Medical Institution. With two new surgical suites, the facility provides surgical procedures as well as other medical care. Correctional Medical Services (CMS), a private firm that has extensive experience in providing outpatient care in prisons and jails around the country, provides all clinical staff and management under a contractual arrangement with the Department of Corrections. No other prison hospitals under contract with private firms were identified in our survey of state and local governments.

Not only are there no other contracted facilities, there are very few prison hospitals under any form of management, apart from the six operated by the Bureau of Prisons. Nearly all state and local government corrections departments send prisoners needing hospitalization to local hospitals in the free community and do not attempt to run a hospital within prison walls. (Appendix A contains broader discussion of health care delivery and contracting at the state and local levels.) Some of these community hospitals have secure wards that are used exclusively for prisoners, but they are still part of a larger hospital that is administered as any other hospital. In these instances,



the locked wards share with the "free" sections of the hospital all clinical staff, diagnostic services, administrative overhead, and so forth. The security staff is an extension of the state or local corrections department. Some local governments (e.g., Los Angeles County) operate small skilled-nursing facilities, and a handful of state correctional departments operate hospitals exclusively for prisoners. California, for example, has a facility in Vacaville for the State Department of Corrections. The Texas Department of Correction owns a facility in Galveston, Texas, on the grounds of the University of Texas Medical Branch and contracts with the Medical Branch for professional services. All of these are staffed by public employees.

Because the number of prison hospitals is so small, an industry with numerous experienced firms will probably never emerge. Some firms that have contracted with a variety of state and local government correctional departments for outpatient care may—like CMS—be interested in bidding on an offer to contract for professional services and management of a Bureau of Prisons hospital.

There does exist a substantial industry providing management services to hospitals, but these hospitals have all been in the free community. These firms have developed their expertise operating hospitals in a very different environment. The Bureau's hospitals, because they are so enmeshed in a larger network of organizations, do not present opportunities for the many of the managerial innovations that these private firms have employed in free-community hospitals, as discussed below in Chapter 4. These constraints may make the prison hospitals uninteresting to these firms.

#### **A Local Hospital as Contractor**

One possibility is not to rely at all upon either the national correctional health care firms or the hospital contract management industry, but instead to have a free community hospital near a referral center assume managerial control of the center. This would be somewhat similar to what the Bureau currently does now in Duluth, Minnesota. A single non-profit hospital in Duluth—St. Luke's—contracts with the Bureau to provide all health care services to the prisoners in the facility, outpatient as well as inpatient. According to those interviewed, the experience has been a good one for the Bureau. The relevance of this model for the management and operation of a referral center is very limited, however. The Duluth facility does not have a referral center on site, and all inpatient care would be provided by a local community hospital anyway, whether the contract with St. Luke's existed at all. The only new service that the St. Luke's provides under the contract is outpatient care at the facility. This is a

far cry from what would be involved in contracting for the management of two of the referral centers--Rochester and Springfield--because both of these centers are hospitals rather than simply outpatient clinics.

The model might be most applicable, and most feasible, at the Lexington, Butner, Terminal Island, and Fort Worth referral centers. The Lexington referral center is limited in the type of inpatient services it delivers, and it makes heavy use of outside consultants and three nearby hospitals. As Table 1.2 in Chapter 1 shows, on an average daily basis during FY 1988, there were five women in nearby hospitals for medical or surgical treatment, compared to two patients in hospitals near the Rochester or Springfield centers. Prisoners from Lexington also are sent out to nearby hospitals for a much broader range of services than Rochester and Springfield provide in-house. During FY 1988, about two-thirds of the average daily expenditure for patients under the care of the Lexington referral center paid for services delivered by non-Bureau providers. This was a much higher percentage than at the three other major referral centers (approximately 25% at Butner, 19% at Springfield, and 25% at Rochester). Contracting with one of these nearby hospitals for a package of services that would contain inpatient services at the hospital, and services to inpatients and outpatients at the referral center, would not require the same kind of qualitative leap that would be involved in assuming control of a large, nearly full-service hospital that Rochester and Springfield represent.

One practical complication in such an arrangement would be the bundling of physicians with a single hospital. At present, the referral center at Lexington uses a wide variety of consulting physicians, and they have different preferences for and privileges at nearby hospitals. A hospital interested in obtaining a contract for all medical services would have to negotiate agreements with the necessary physicians for their services.

One feature of the Lexington facility that makes it especially amenable to this kind of contractual arrangement is the restriction on being able to transfer women to either Springfield or Rochester for treatment. Because the latter two centers are for men, Lexington does not have the inexpensive option of transferring women to them for treatment and must depend instead upon the local community hospitals (which, for some services, may be less expensive than transferring to Springfield or Rochester).

The referral center at Butner is also more suited to this kind of arrangement than Springfield or Rochester because no medical or surgical treatment is done there. All inpatient medical/surgical care is provided either by local community hospitals or

by one of the other referral centers. Unlike Lexington, however, Butner has the option of transferring patients needing medical or surgical inpatient treatment to either Springfield or Rochester. As long as any beds are available in these latter two facilities, or in any other similar referral center that the Bureau may establish in the future, the marginal cost of transferring prisoners to these facilities and treating them will be lower for many types of services than in the local community hospital. (The relative costs of treatment at the referral centers and nearby community hospitals were discussed above in Chapter 2.)

The smaller referral centers at Fort Worth and Terminal Island may also be suited to such a contract for similar reasons as Butner: they already depend on nearby hospitals for a wide variety of medical and surgical services because they cannot provide them directly. But like Butner, they also have the option of transferring prisoners needing more extensive or complicated inpatient treatment to Springfield or Rochester, the marginal cost of which is less than for treatment in nearby hospitals except for the least expensive types of treatments.

Whether or not a contractual arrangement with a single hospital is feasible at all depends upon whether there are local hospitals interested in providing the service. Whether it will be economically attractive to the Bureau depends in part on how many potential competitors there are in each area. In Rochester, the Mayo Foundation might have an interest in administering clinical services at the referral center. (This is pure speculation; no attempt was made to determine the nature or extent of private sector interest in managing the referral centers.) There is little reason to think that such an arrangement would be economically attractive to the Bureau, however. The Mayo Foundation has a near-complete monopoly on hospital services in the area, owning not only the Mayo Clinic but also the two major hospitals in Rochester. In such a non-competitive environment, the Bureau would have little negotiating leverage over the terms of the contract's payment provisions once it decided to contract out for professional clinical services.

Springfield and Lexington both operate within a somewhat more competitive environment. In Lexington, Kentucky, there are five private general purpose hospitals and one university hospital. In Springfield, Missouri, there are three private general purpose hospitals. Butner operates in a non-competitive environment, there being only one hospital in the city. The potential for reducing costs by such a contractual arrangement in these referral centers is examined in Chapter 4.

### Testing Market Interest With An RFP

Because of the idiosyncratic nature of the Bureau of Prisons hospitals, the only reliable way of assessing private sector interest in a management contract would be to issue a request for statements of "Qualifications and Interest" from prospective contractors. This should specify precisely not only the referral center and the activities that would have to be provided, but also the nature of the larger Bureau-wide health care system, the method by which assignment of hospital beds is made, and the constraints on being able to transfer prisoners out of the hospital.

### Contracting for Specific Departments

Whether it is feasible to contract for the management and operation of specific departments at one or more referral centers, in addition to or in the absence of a broader contract for overall referral center management, depends on much narrower considerations. Departmental contract management (or "specialty contract management") is the fastest-growing segment of the hospital contract management industry. Indeed, most contracts in hospitals are for departments only, and not for full-service management.<sup>3</sup> It is possible that specific services that the referral centers cannot now provide themselves might be purchased from a national firm. Or such services might be obtained through a contract with a local hospital, which might be able to achieve advantageous economies of scale if the referral center's demand is coupled with the community hospital's demand. (The necessity of providing the service at two sites--the local hospital and the referral center--would limit the ability to achieve advantageous economies of scale in many services, however.) Many of the specialty contract services offered by the national firms are not needed at the referral centers. These include food service, housekeeping, laundry, materials management, plant operations and maintenance--which represent a large proportion of all contracts with hospital departments. Others, however, such as certain diagnostic services, might be more cost-effective to provide under contract.

Determining which services at which referral center might be advantageously contracted, with a local hospital or a national firm, was not attempted here. The "make/buy" decision requires balancing the relative costs and benefits of providing the services directly, of purchasing them on an as needed basis from local community hospitals or physicians, and of purchasing them in volume from a national firm. Hospital administrators are in the best position to make judgments about the feasibility and economic advantages of contracting for specialized services.

### Legal and Administrative Constraints

There are no legal barriers in statutory or administrative law to contracting for clinical services, including the management of those services. Inmate health care is provided under a full-service contract with St. Luke's Hospital in Duluth, Minnesota. Service contracts of other sorts are in existence at a number of other facilities, and there is no legal reason why the provision of medical services would be considered differently. Indeed, the Bureau is even legally able to contract for all imprisonment services in a privately-owned and operated facility. Sentenced inmates are committed to the custody of the Bureau of Prisons, and the Bureau has the authority to designate the place of confinement. The Bureau may designate any available penal or correctional facility that meets the minimum standards of health and habitability established by the Bureau, regardless of whether the facility is operated by the Federal government, and regardless of the facility's location. Authority to contract with the States, territories, and political subdivisions is established in statute (18 U.S.C., Section 4002; 18 U.S.C., Section 5003). Authority to contract with private vendors is guided by procurement law.<sup>4</sup> In short, there is sufficient legal authority to contract for any range of services at any of the referral centers.

### Administrative Constraints

At present, there are several security regulation restrictions on contract employees that would have to be changed if a private firm were engaged to perform clinical services, or hospital management services. For example, many employees currently working under contract with the Bureau may not move through the facilities unless they are escorted by a correctional officer. Some are given permission to walk about unescorted, however, largely because they have completed a Bureau training program in facility security. Associated with this is the ability to work out of a correctional officer's sight. Many consultants who work with prisoners are required to be under the constant surveillance of a correctional officer, while others are permitted to work in areas less completely supervised. Were more extensive contracting for medical services begun, the Bureau would have to establish or refine its policies for surveillance and escort so that all interests—those of the contractor and of the Bureau—were sufficiently protected.

How this is resolved has substantial fiscal implications. At present, all health care workers employed by the Bureau have the ability to walk about unescorted, which

permits them to take patients from one part of the facility to another without having to detail correctional officers to accompany them. If a contractor were not permitted to do this, the Bureau would have to bear a heavier cost for additional correctional officers. (These and similar fiscal implications of contracting are discussed at greater length below, in Chapter 4.)

Related to this is the responsibility for carrying keys. At present, no employees working under consulting contracts carry keys within the facility. This is the sole prerogative of the Bureau-employed staff, including Bureau-employed health care workers. If contractors were not permitted to carry keys, the correctional officer workforce would have to be increased to man all locked doors. Another option is to establish new administrative regulations permitting contract employees to carry at least some keys needed for their duties. This can be accomplished administratively. The Bureau would have to determine what kinds of new procedures and training requirements would have to accompany the extension of this privilege.

### Liability

It is well-established in law that the Bureau retains legal liability for services rendered by contractors. The Federal government's liability for privately detained prisoners was affirmed in a case involving a death of an illegal immigrant trying to escape from a privately operated holding cell (Medina v. O'Neill, 585 F. Supp. 1028, 1984). In a more directly applicable case, the U.S. Court of Appeals, Eleventh Circuit, held that the provision of health care services in a Florida jail by a private firm acting under contract constituted a "state action" for the purposes of establishing the government's liability (Ancata v. Prison Health Services, Inc., 769 F.2d 700, 702 1985). The U.S. Supreme Court reaffirmed this principle in West v. Atkins, 56 U.S.L.W. (U.S. June 20, 1988), in which the court considered the question of "whether a physician who is under contract with the State to provide medical services to inmates at a state-prison hospital on a part-time basis acts 'under color of state law,' within the meaning of 42 U.S.C. Section 1983, when he treats an inmate."<sup>5</sup> The Court concluded that it did.

Contracting out prison medical care does not relieve the State of its constitutional duty to provide adequate medical treatment to those in its custody, and it does not deprive the State's prisoners of the means to vindicate their Eighth Amendment rights. The State bore an affirmative obligation to provide adequate medical care to West; the State delegated that functions to respondent Atkins; and respondent voluntarily assumed that obligation by contract.<sup>6</sup>

Because the Federal government will not be able to shield itself from liability for the contractors' actions, the government should establish clear standards of care and should monitor contractors' performance.

#### "Political" Considerations

Contracting for health care operations or management would affect the interests of three different groups--the existing Bureau-employed health care providers, correctional officers, and the contractors themselves. A change in the duties of the contractors will affect the interests of the other two. Some of these interests can be accommodated by administrative changes, while others can be negotiated in the contracts.

If all clinical duties at a referral center are assigned to a contractor, existing staff will need to be reassigned (unless the staff are hired by the contractor). At present, there would be little need, if any, for a reduction in force, with layoffs, because there are shortages in nearly all categories of health care workers throughout the Bureau. There may nonetheless be some resistance to being reassigned, but bringing in a contractor to operate one referral center would not necessarily result in a loss of jobs for Bureau personnel. If more than one referral center were contracted out, however, the impact on jobs would be greater (unless an additional Bureau-operated center were established in the near future).

If only management responsibilities were contracted for, the impact on the Bureau's employees keeping their jobs would be much smaller, of course.

Contracting for all clinical duties would affect also the workload of the correctional officers. At present, correctional health care workers employed by the Bureau and PHS are trained at the academy at Quantico, Virginia, and have multiple responsibilities. They have responsibility for supervising inmates who work in the referral centers; they can write inmates up for disciplinary infractions; and they will respond with all other Bureau employees to a "custodial emergency," any incident requiring immediate staff intervention, such as a fight, riot, escape, etc.<sup>7</sup> Whether or not the correctional officers would have more work shifted to them upon contracting for health care would depend upon the types of duties that contractors would be obliged to perform (e.g., escorting prisoners), whether contractors would be able to have keys for gates, and whether they would have the ability to supervise inmates performing

various support services. It would also depend upon whether the Bureau increased the number of correctional officers on staff to accommodate a heavier burden.

The contractor's interests are affected by a wide variety of things, such as the flow of patients into the centers for treatment, the time it takes to transfer them out, the equipment provided by the Bureau, restrictions on use of the facilities, and, more generally, the ability to control a wide variety of workplace conditions. Depending upon how payment to the contractor is made, different types of incentives will be created that may affect the contractor's ability and willingness to accomplish certain duties at the expense of others. For example, if payment is not contingent upon the numbers of people admitted and discharged for treatment, but for maintaining a certain number of beds full, the contracting firm may find it in its interest to slow down transferring prisoners out, thereby slowing down the pace of admissions and the heavy work that has to be done at the front-end of a patient's stay. This would have an unwanted distributional effect on the other referral centers: the demand for those other centers' beds would increase. Or, an arrangement whereby the contractor is paid for each unit of service delivered creates an incentive to provide more units in order to increase revenues. If payment is based on an average cost per service, a possibility is created for a large profit for the contractor, and a large expenditure by the government. To protect against this possibility, payment might be based on some approximation of the average cost and a marginal cost for additional units of service. That is, the contractor may be assured of a specified number of units, to be paid at a price that approximates the estimated average cost of treating that number of inmates, plus a reasonable fee. If the number of units exceeds that number, payment might be based on a sliding percentage of the average cost in order to cover the contractor's marginal costs, without passing on huge profits for these additional units. This will be especially important to consider if the contract is based on units of treatment delivered rather than per diem bed costs.

Unfortunately, the existing experience at the Duluth facility does not provide a model for contracting clinical services at the referral centers. The Duluth contract pays St. Luke's hospital a fixed price for providing all services to prisoners at the facility. This price remains the same as long as the average daily population in the prison ranges between 750 and 825 inmates. If the population increases, a monthly fee based on a rate of \$45/day is paid for all prisoners in excess of the 825 average daily population. This kind of arrangement is well suited to a situation where the population to be treated is relatively stable. Referral centers operate differently. They are



processing organizations that receive prisoners from over fifty prisons throughout the country. A payment scheme based only on an average daily population does not make sense because the size of that daily population is affected directly by the actions of the hospital administration and staff. To keep beds from filling up with prisoners staying for long recuperation periods, some other method of payment is needed to reflect the processing character of the referral center and to create appropriate incentives.

Nor do the state and local government contracts with correctional health care firms provide good models. They resemble the Duluth contract, with variations, because the services they provide are based upon a prisoner population within a certain range. The facilities they serve are prisons, and not referral centers. (See Appendix A.)

One possible solution might be for private contractors to bill the Bureau for services performed, with some adjustments for average and marginal costs at various levels of service. This will require creating a billing system in the referral centers. A private management firm could devise such a system, but this will be at an additional cost, and a substantial one, at that. There are other benefits to establishing a pricing system within a referral center, however. These include obtaining better information about what it costs to deliver a unit of service in these centers, information which is useful in determining how much in-house treatment capacity to create as opposed to relying more on outside hospitals.

Inventing a contractual structure to regulate the contractor's performance at a referral center is a complicated task, which is beyond the scope of our task here. If such a contract is to be developed, the Bureau might find it profitable to consult with the contract officers at the Immigration and Naturalization Service, who have a relatively long experience contracting with private providers for detention centers, and with contracts officers in the Department of Defense who are experimenting with different methods of delivering health care services to CHAMPUS-eligible persons.

### **Tensions Between Security and Clinical Concerns**

Contracting for management of medical care in the referral centers may exacerbate an already existing tension between clinical and security concerns, or, by extension, between the medical and security staff. These tensions surface, for example, when the medical staff requests an inmate's immediate transfer to an outside hospital for treatment. Especially for prisoners classified as high-security risks, the necessity for taking security-oriented precautions may create delays, questions about

whether transfer is really needed, and so forth. The warden of one referral center, who had served previously as the warden of the Duluth facility (where a local hospital has a contract to provide all health care to the facility's prisoners), remarked that the difficulties in managing such a relationship between the prison and a contractor would be enormous, even "horrible." These predictions need not be taken as gospel, however, because procedures could undoubtedly be devised to facilitate an efficient working relationship.

### Summary

Transferring ownership of any of the existing facilities to a private provider is infeasible for two principal reasons. First, there is not a competitive market for firms that provide management services for prison hospitals, and the risks of being "captured" by a monopolist contractor are too high. Moreover, even if there were a competitive market, transferring ownership of the needed assets to one firm would endow that firm with an advantage that potential competitors would find difficult to overcome, creating monopoly conditions.

The idiosyncratic character of the prison hospital, and the absence of a specialized management industry for these types of organizations also makes a "full-line" management contract of all clinical services of questionable feasibility. Local hospitals might be interested in negotiating a management contract for all clinical services, but the opportunity for competitive bidding among local hospitals exists only in Springfield and Lexington. Given the complexities of privatizing the hub of a nationwide health care system--the Springfield referral center--and the potential disruptions that could ensue, it would be easier to implement a private management contract at the Lexington center. The fact that the Lexington center serves women only would insulate the larger system from many of the effects of privatization. This could be an advantage, to the extent that one aimed to contain the disruptive effects on the larger system, but it also would be disadvantageous if one hoped to stimulate changes throughout that larger system.

Contracting for more specialized services, for the management and operation of specific departments within the referral centers (e.g., physical therapy, pharmacy, radiology), appears to be easiest of all to implement.

## Endnotes

1. Charles Logan reviewed an early version of this report and challenged this assertion by noting that the Wackenhut Corrections Corporation, a private prison firm, has developed its health services capacity. It is true that private prison firms provide the health services customarily available in prisons, but these are outpatient rather than inpatient hospital services. For inpatient services, private prisons do what nearly all public prisons do: send the patient to a nearby hospital.
2. Charles Logan, referred to in note 1, challenged this assertion as well, pointing to the existence of a competitive market for private prisons and for private correctional healthcare firms. He argued that firms from these two industries could team up and bid against one another. It is indeed true that competitive markets for both exist, but the correctional healthcare firms have meager experience in managing and/or providing inpatient hospital services. As indicated below, only one private healthcare firm is developing expertise in prison hospital management (CMS in Georgia).
3. See Sandy Lutz, "Management firms emphasize efficiency, quality, as hospitals scrutinize their costs," (results of the annual contract management survey), Modern Healthcare (August 25, 1989).
4. Matthew J. Bronick, "The Federal Bureau of Prisons' Experience with Privatization," photocopy of an unpublished paper (Washington, D.C.: Federal Bureau of Prisons, October 1989), pp. 14-15.
5. 56 U.S.L.W., at 4665.
6. Ibid., at 4668.
7. One reviewer of this report, Dr. B. Jaye Anno, argues that combining clinical and correctional responsibilities is against the trend in state and county facilities and "should be questioned at least." (Memorandum to author, dated January 3, 1990). No attempt was made here to evaluate the desirability of this practice.

## CHAPTER FOUR

### IS CONTRACTING FOR MANAGEMENT OR OPERATION LIKELY TO REDUCE SPENDING?

Aside from the feasibility of contracting, it is worth asking if contracting for the management or operation of the referral centers is likely to result in reduced spending for healthcare services or, at least, improved efficiency so that the same level of expenditure generates more or better services. This chapter describes briefly the development of the hospital contract management industry, the reasons why hospitals turn to contract management, and reviews the findings of several studies of contract management's effects on service delivery and costs. It concludes by assessing the likelihood that contract management will bring greater efficiency to the referral centers' operations.

#### A Brief History of Contract Management

After World War II, not-for-profit and public facilities provided the dominant share of hospital health care.<sup>1</sup> In 1964, as a consequence of an increasing awareness of the differences in quality of care between public hospitals and other facilities, Congress established the Medicaid and Medicare programs. Under both programs, health care could be provided at any facility, and was paid for by the federal government. Until 1983, reimbursement for Medicaid and Medicare was cost-based, including allowances for a return on invested capital whenever the service was provided by a for-profit facility. This policy made large amounts of public funds available to the private profit and non-profit sectors for the provision of health care, with little monitoring of price-making procedures.

This regulatory change ultimately had major consequences, including tremendous growth in the hospital industry, the development of multi-institutional arrangements among hospitals, and contracts with private firms.

#### Growth and Change in the Hospital Industry

The Medicaid/Medicare programs increased demand for health services and created a new kind of health care customer able to choose a facility and afford its cost through public payment. Credit ratings of hospitals became more favorable as a consequence of their financial backing by government or large insurance groups, which aided capital investment for the construction or acquisition of hospitals.<sup>2</sup> Because

reimbursement was cost-based, the incentives for hospital chains to contain costs were not compelling. On the contrary, the acquisition of a new hospital offered a profit-making opportunity by revaluing its assets, and raising the per diem hospital charges reimbursed by the federal government (to recover the now higher-valued cost of capital assets). By virtue of this accounting practice, the private for-profit hospital industry captured large sums of public monies to finance its further growth. In 1981, for example, Hospital Corporation of America purchased Hospital Affiliates International for \$1.3 billion and added \$500 million to its book value by correctly revaluing its assets.<sup>3</sup>

Subsequently, Congress decided to make this practice of revaluing assets illegal and moved towards creating more competitive market conditions in health services provision. Thus, in FY 1984, the prospective payment system, and the Diagnostic Related Groups (DRGs) that were created as part of it, established a reimbursement system based on fixed prices for admissions in each DRG rather than on the costs to the hospitals of providing the service.

The development of the Medicare/Medicaid programs also stimulated a change in the hospital industry by rewarding market-oriented management practices (such as aggressive billing techniques, marketing capabilities and accounting innovations) that were typical of the private sector but totally new to public hospitals. In addition, public hospitals were often old, under-equipped, and under-financed, and therefore unable to compete successfully.<sup>4</sup> Many hospitals had to close, including large urban facilities such as the Philadelphia General Hospital in 1977, and the Homer G. Phillips hospital in Saint Louis in 1979. Others, especially small and rural facilities that had structural problems in addition to facing this more competitive environment, turned to contract management to survive. The existence of a pool of non-competitive public hospitals provided a large market for the management companies to develop their expertise; in 1983, 40.1 percent of their clients were state and local hospitals.<sup>5</sup>

#### **Development of Contract Management**

In the late 1970s and early 1980s, a shift occurred in the private for-profit industry from hospital ownership to providing hospital management services. This shift was encouraged by rising interest rates, among other conditions. As it became more expensive to borrow in order to finance hospital acquisitions, the provision of industry expertise to provide management services to other hospitals was sought as a means of maintaining company growth. In 1970, only 14 hospitals had contracted out their

day-to-day management.<sup>6</sup> By 1980, according to the American Hospital Association, there were 397 such contracts; by 1985, the number had grown to 595.<sup>7</sup>

It is interesting to note that the Bureau's referral centers have many of the features that characterized public hospitals, which supported the growth of the contract management industry in its heyday. As in public hospitals during the pre-Medicaid/Medicare era (i.e., before 1964), services are delivered largely outside of a price-driven market; revenues are provided by government appropriations and services are delivered at no cost to prisoners (in the Bureau) or to indigents (in the case of public hospitals). Lacking the necessity of charging patients, the referral centers, like the public hospitals in the pre-Medicaid/Medicare era, have no experience with billing. It was these kinds of organizations that sought out the services of hospital management firms. By 1984, approximately 40 percent of all hospitals under contract management were state or local government hospitals; another 46 percent of them were secular non-profit hospitals, many of which provided essentially public services in a similar fashion.<sup>8</sup>

The term "contract management" includes a variety of different organizational forms. The most comprehensive entails the day-to-day management of an entire health facility by a separate organization that reports to the board of trustees of the managed institution. The personnel provided by the contracting firm may range from a single hospital administrator to a larger management team. (This is sometimes referred to as "full-line" contract management.) A more limited form involves contracting for the management of specific departments of a hospital ("specialty contract management").

The growth of specialty contract management was stimulated by the creation of the federal prospective payment system in FY 1984, which altered radically the economic environment in which the industry operates. With reimbursements based on prices set by the government rather than on costs, incentives were created for hospitals both to contain costs and to concentrate their activities in services where the expected reimbursement was higher than their production cost. The existence of gaps between cost and price provides profit-making opportunities for specialized companies able to reach large economies of scales in areas where services are overpriced. Specialty firms also are able to provide smaller hospitals with services that the hospitals themselves cannot provide easily, although larger hospitals also are signing up specialty firms when labor shortages in certain occupations make it difficult to "make" the service directly. As a result, specialty contract management has been increasing faster than full-line contract management, and currently dominates the market.

The number of hospitals contracting for full-line management services has declined in recent years, partly because of a decrease in the number of small rural hospitals, which provided a large market for contract management services, as well as a more general squeeze on hospital profits. Full-line contract management also may be less profitable than specialty management because of the limited ability since FY 1984 to mark up the prices for services. The Hospital Corporation of America's recent selling off of its hospital management company may be an indicator of the softening market and declining profitability in the full-line industry (and of inpatient hospital care more generally).

#### **Reasons for Choosing to Contract for Management Services**

A number of reasons are mentioned in the published studies to explain the choice of contracting for management services. Much of this information is collected from surveys of hospital board members, and therefore represents board members' perceptions rather than established truth about what contract management has actually done for these hospitals.

##### **Financial pressures**

These include cash flow management problems, lack of adequate billing procedures, bad credit ratings, large amounts of bad debt, and long debt-collection periods. In this area, the management company is thought to bring financial expertise and more skill and power to negotiations with other organizations, such as third-party payers or banks. Management companies also own data files relevant to their industry, which reportedly gives them ability to compare their operations with others and to diagnose better a specific hospital's problems.

##### **Operations problems**

These include recruitment difficulties or staff shortages, high personnel turnover, lack of a marketing policy, low occupancy rates, problems with size or location, deficits in a number of departments, difficulties dealing with regulatory requirements, and inadequate strategies for capital investment, innovations, or long-term planning. Usually, a management company will have access to larger resources, such as a national network for recruitment, a marketing department within the company, a network for mass purchasing at lower cost, or networks for shared services. By running many hospitals, management companies can attain, it is argued,

economies of scale in certain areas. The contract management option also provides the ability to take advantage of multi-institutional arrangements while maintaining autonomy and keeping policy decisions within the hospital's board of directors.<sup>9</sup>

#### Need for an Outsider

Boards may decide to chose outsiders to resolve internal conflicts between medical and administrative personnel, between the board of directors and the management, to implement unpopular but needed changes, or to overcome a bad reputation.

#### Comparing Reasons for Choosing Full-Line and Specialty Contract Management

Two different surveys of board members and hospital administrators indicate the different motivations behind contracting for full-line and specialty management services. In their 1985 survey of board members in 168 hospitals managed under contract by the Hospital Corporation of America, Kimberly and Rosenzweig identify the five top-ranking reasons given to justify decisions to contract for full-line management:

1. Need for management expertise
2. Physician recruitment and retention
3. Unsatisfactory or retiring administrator
4. Rising expenses
5. Declining revenues.<sup>10</sup>

A 1984 survey by Modern Healthcare of department (or specialty) contract management asked similar questions to hospital administrators who contracted out for specialty services only.<sup>11</sup> The top priorities listed by administrators who make the contracting decisions included:

#### Cited by:

- |                              |     |
|------------------------------|-----|
| 1. Controlling staff costs   | 48% |
| 2. Profitability             | 47% |
| 3. Controlling supply costs  | 46% |
| 4. Decreasing length of stay | 45% |
| 5. Quality assurance         | 44% |

It is somewhat difficult to compare the answers provided for full-line contract management and for specialty contract management because the questions asked were



different and readers are not provided with the total list of questions asked in each survey. However, the data suggest that administrators choosing specialty contract management are more concerned with cost containment (three of their first five priorities are related to cost) than are boards opting for full-line contract management (none of the boards' first three priorities are directly related to cost).

### **What Benefits Does Contract Management Actually Bring?**

Giving reasons for choosing to contract is not the same thing as establishing how contract management has actually affected the operation of hospitals. To determine that impact, several analysts have undertaken empirical studies. To date, these studies have examined only the full-line contract management phenomenon. Impact studies of specialty contract management have not yet appeared in the published literature. A more significant limitation for our purposes here is that many of these studies compare profit-seeking with non-profits, rather than public with private or public with profit-seeking private hospitals.

In one study, Kralewski et al. compared twenty matched pairs of non-profit community hospitals throughout the United States, using twelve performance indicators.<sup>12</sup> Although they used a small sample of hospitals, the results are particularly reliable because they analyzed time-series data for three years before and after half of the hospitals turned to contracting. They found that full-line contract management did not improve productive efficiency (either by reducing expenses or by increasing the quantity of service created), and that it left unchanged the following characteristics:

- admissions
- beds
- occupancy rates
- average length of stay
- employee/patient ratios
- payroll expenses /total expenses
- number of employee/number of beds
- net patient revenue/total revenue

The main change was a significant increase in charges for services delivered (measured by gross patient revenue over total expenses), resulting in significant increases in net profit and return on assets. Thus, the main change operated by the

shift to contract management appeared to be a change in the way services were priced rather than produced. Other studies support this general finding (i.e., that full-line contract management improves profitability largely through price or revenue increases rather than through cost-reduction).<sup>13</sup>

This parallels findings of studies of private investor-owned hospitals. In a review of research for the National Academy of Sciences on the for-profit enterprise in health care, a special committee concluded that:

...although standard economic theory predicts greater efficiency in for-profit than in not-for-profit organizations, the expected ability of investor-owned for-profit organizations to produce the same services at lower cost than their not-for-profit counterparts has not been demonstrated. Large organizations theoretically benefit from economies of scale and reduced transaction costs, but such savings may be offset by central-office costs, higher capital costs resulting from a growth orientation, and the payment of taxes and dividends.<sup>14</sup>

These conclusions may now be outdated because these studies examined hospital operations before the shift in FY 1984 from a cost-based reimbursement system to a prospective payment system based on DRG rates occurred. Now that per case DRG rates are used by many payors, the option of raising charges is limited. This constraint may explain why the growth of full-line contract management has been eclipsed by specialty contract management, which aims at exploiting cost-reduction possibilities in smaller niches.

### Changing Mixes of Services

Another strategy full-contract management firms adopt is to change the mix of services provided in the hospitals they have been hired to administer, concentrating on ones that are most profitable or ones that they are most expert at delivering.

Rundall and Lambert studied the influence of contract management on the mix of services offered by hospitals. They used two sets of data: (1) a national comparison between investor-owned and public (state and local) hospitals on population data provided by the AHA annual survey, and (2) a comparison between ten public hospitals in California that are operated under the management of an investor-owned organization and ten matched hospitals belonging to a traditionally managed control group, for three years after contracting with a management firm.

From the first data source, the authors established that there are differences in the mix of services provided by public and investor-owned hospitals. They found that

twelve services were over-represented in investor-owned hospitals while twenty-three other services were over-represented in public hospitals. (These findings also may be somewhat outdated since the establishment of DRG rates in FY 1984 and the impact of these on the profitability of various services.) Among the most prominent differences in over-representation are the following:

Public hospitals	Private hospitals
part-time pharmacies	full-time pharmacies
psychiatric care	specialized laboratories
outpatient care	diagnostic services
	inpatient treatment
	support services

The authors also examined the changes in service mix occurring over three years under contract management, and compared them to what happened in a control group. They found that hospitals under contract management were significantly more likely to add:

- mixed intensive care units
- abortion services (inpatient)
- abortion services (outpatient)

while they significantly dropped:

- occupational therapy
- psychiatric outpatient service
- psychiatric emergency service
- clinical psychology service

#### **Contracting in the Referral Centers and the Prospects for Higher Efficiency and Lower Costs**

The discussion above indicates that there is little evidence that the full-line management industry has relied principally upon cost-reduction strategies other than shedding unprofitable types of services. The growth of that industry appears to have resulted instead from more aggressive revenue collection strategies and marketing techniques, and from changing the mix of services toward more profitable ones. Better marketing will not be of value to the current Bureau system, given the way resources are allocated. The referral centers do not operate within a market where healthcare is

paid for on a pre-service basis. Nor is there a DRG-like system of fixed payment schedules, which creates an opportunity for enhancing revenues by manipulating patient mix. Instead, resources are allocated by officials at higher levels within the Bureau of Prisons and other agencies of government (the Office of Management and Budget, and Congress).

In addition, there are powerful structural reasons why full-line contract managers will be limited in their ability to reduce costs. In the free community, managers of privately-managed hospitals are permitted considerable latitude to change the patient mix and to shed unprofitable services. This has incurred large social costs, but managers have been free to pass those costs onto the public sector. (Public hospitals have been given a heavier burden of caring for the least profitable patients at the same time that more profitable patients--those with private health insurance or those needing treatments that can generate DRG-based revenues that are higher than costs--are being drawn away from the public hospitals to private ones. This has plunged public hospitals into a severe fiscal crisis.) This is not possible within the Federal Bureau of Prisons' healthcare system. If some kind of price system were created in the referral centers with fixed-reimbursement schedules, and if managers were permitted to pick and choose their patients while shedding those that were least profitably treated, the Bureau would still have to bear the cost of those who were shed. These latter patients would have to be treated in local community hospitals at a cost to the Bureau, or in other referral centers. This would create a system-wide inefficiency because the Bureau would probably not be able to negotiate contracts with local hospitals to pay for these services on any basis other than cost-reimbursement.

It is possible, of course, that full-line contract management firms could reorganize the production of the referral centers' services, without having to control either the stream of public funds or prisoners/patients, so that costs could be reduced. The existing studies of full-line contract management do not document the extent to which such cost-reduction has been accomplished successfully in hospitals that have contracted with private firms, but there may be opportunities to do so.

### **Specialized Contracting**

Specialty contract management may be better able to exploit cost-reduction opportunities by taking advantage of economies of scale. The cost-effectiveness of contracting for departmental services has not been demonstrated in the literature (neither has the reverse proposition), but the fact that hospital administrators are

typically the customers for such services, rather than hospital board members, suggests that there may be a strong economic rationale for choosing to contract for these specialty services. The relative advantages and disadvantages of "buying" rather than "making" specific types of services vary widely according to the demand for such services, the ability of the hospital to provide directly, the cost of capital associated with specific services, the ability to recruit specialists, and so forth. To identify specific opportunities for contracting rather than for direct provision, or vice-versa, was beyond the scope of this study. Armed with better utilization and financial data than now exists, referral center administrators could improve their ability to identify good prospects for specialized contracting. (This would require better procedures for collecting and analyzing information--a point discussed in Chapter Six.)

## Endnotes

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2. Ibid.
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4. Jeffrey A. Alexander and Thomas G. Rundall, "Public Hospitals Under Contract Management," *Medical Care* 23:3 (March 1985), 209-219.
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10. John R. Kimberly and Philip M. Rosenzweig, "Hospital Boards and the Decision to Renew the Full Service Management Contract," *Hospital & Health Services Administration* 13:4 (Winter 1988), 449-465.
11. Linda Punch, "Contract Management Companies Manage Growth Rate of 13.3%," *Modern Healthcare* (Aug. 15, 1984), 42-52.
12. John E. Kralewski, Bryan Dowd, Laura Pitt, and Errol L. Biggs, "Effect of Contract Management on Hospital Performance," *Health Services Research* 9:4 (October 1984), 479-488.
13. Alexander and Rundall, "Public Hospitals."
14. Bradford H. Gray (ed.), *For-Profit Enterprise in Health Care*, (a report of the Committee on Implications of For-Profit Enterprise in Health Care) (Washington, D.C.: National Academy of Sciences, 1986), 186-7. See also the study by Craig G. Coelen in the same volume, "Hospital Ownership and Comparative Hospital Costs," 322-353. In his statistical analysis of charges, costs, utilization rates, and margins in a sample of several thousand hospitals, Coelen reports that "[our] findings clearly dispute the presumed advantages of chain-operated hospitals in general, and proprietary chains in particular, from economies of scale and profit-related incentives for minimization of cost." (at pp. 325-6).

## CHAPTER FIVE

THE POSSIBLE IMPACT OF  
PRIVATIZATION ON THE  
QUALITY OF SERVICE DELIVERY

Whether it is feasible to privatize one or more referral centers turns also on the likelihood that the quality of service will be affected following the conversion of those referral centers from public to private management. As the preceding chapter has noted, there is no base of experience in contracting for the operation of prison hospitals at the state and local level. Few prison hospital facilities exist and only one has operated under private sector management (since mid-1989), providing no opportunity to assess quality of service issues. For guidance on these issues, we turned instead to studies of the experience of general community hospitals, and of state and local corrections institutions that have contracted for prison-based health care services.

## Non-Prison Hospitals

Concerns about the quality of health care in profit-making hospital settings (particularly those operated as part of a chain of proprietary hospitals as opposed to the more traditional, independent proprietary) are founded on the assumption that the economic interests of providers may conflict with the health care interests of patients. There are, however, very few empirical studies of the relationship between organizational status and quality of care.

Measuring the quality of hospital care is decidedly difficult. Quantifiable patient outcomes (such as mortality or post-surgical readmission rates) and patient care practices (lengths of stay, rates of elective surgical procedures) are imperfect indicators of quality, subject to a variety of influences that defy reliable measurement. A 1986 report of the Institute of Medicine's Committee on Implications of For-Profit Enterprise in Health Care reported only one major attempt to examine the relationship between patient outcomes and hospital ownership status—and this study compared not-for-profit and for-profit ownership, not private with public.<sup>1</sup> Commissioned by the Committee, this study examined mortality and re-admission rates among Medicare patients admitted to a sample of private U.S. hospitals between 1974 and 1981.<sup>2</sup> No conclusive evidence was provided that profit-seeking hospitals had either improved or compromised patient care.

On other measures related to quality--hospital accreditation, physician certification, and quantity of nurses--the Committee found that "differences between investor-owned and not-for-profit institutions are small and the direction of the differences varies."<sup>3</sup> Investor-owned hospitals were slightly more likely to be accredited by the then Joint Commission on Accreditation of Hospitals (JCAH). On the other hand, there was some evidence that those hospitals were less selective in approving physicians for staff privileges and had slightly lower rates of board certification. None of these differences were statistically significant and no differences were found in numbers of nursing personnel per patient. Finally, the board chairmen of chain hospitals reported more quality-related concerns, and a survey of physicians, conducted at the Committee's request, reported that about one-fourth of the respondents with for-profit hospital privileges believed that quality of care was better in not-for-profit settings. The Committee concluded that these limited indicators show no overall pattern of either inferior or superior quality.<sup>4</sup>

The Committee did acknowledge that the early growth of chain providers may have improved overall levels of quality since hospital chains have tended to acquire independent proprietaries--a class of hospital with notably low accreditation rates. Combined with evidence that the hospitals acquired by the chain providers may have been poorly managed and had labored under weak financial structures (problems that could have quality implications), a picture emerges of a group of hospitals that may have had nowhere to go but up.

The Committee concluded that the cost-based reimbursement environment that stimulated the growth of hospital chains minimized potential conflicts between profit motivation and patient interests. With the economic and competitive changes that have taken place in the health care sector since the establishment of fixed DRG prices, standards of quality may be shifting. Foreseeing greater pressures to cut corners, the Committee called for additional research to develop and validate more sensitive indices of quality, and for increased monitoring of patient outcomes in all types of hospitals.

Responding to the call for increased research on the relationship between quality of care and the new pressures on hospitals to reduce costs, Shortell and Hughes examined inpatient mortality rates as a function of various measures of regulation and competition.<sup>5</sup> Significantly higher mortality rates were observed among hospitals that faced severe regulatory constraints or operated in highly competitive markets. No differences were found between independent hospitals and those affiliated with a multi-



hospital system. Rather, hospitals of any type appeared to be responding to the pressures of regulation and competition in ways that may negatively affect the quality of patient care.

Data that more directly address the comparison of public and private hospitals are shown in a 1986 study of physicians' evaluations of hospitals.<sup>6</sup> Approximately 3,200 physicians were asked to compare the hospital with which they were primarily affiliated with those that they were familiar with. Specifically, they were asked how nursing, hospital administration, patient satisfaction, and technical equipment in their primary hospital compared with others that they were familiar with. A substantial percentage of those working in nonfederal government hospitals reported that their hospitals were worse than other private facilities they were familiar with, whereas a much smaller percentage of those working in private hospitals—either for-profits or not-for-profits so reported. In contrast, a smaller proportion of physicians whose primary hospitals were government ones reported that their hospitals were better than others they knew of. Taken as a whole, these findings indicate that physicians are more satisfied with private hospitals than nonfederal government ones. What they say about the actual quality of care is unclear.

A study published at the end of 1989 compares public with private for-profit and not-for-profit hospitals using a more objective measure of patient outcomes: mortality rates.<sup>7</sup> Analyzing mortality data from more than 5,800 hospitals, researchers found that the death rates per 1,000 Medicare patients averaged 120.8 in for-profit hospitals, slightly lower—120.3—in public hospitals and 114 in private non-profit hospitals. Although these showed a significant difference between not-for-profit and for-profit status, the difference between the for-profits and the public hospitals was essentially nil. Mortality rates are also but one indicator of patient outcomes, although they are strongly correlated with other measures of quality problems in hospitals.<sup>8</sup>

In summary, there is in the published literature no clear and compelling evidence that the quality of care in the referral centers would be affected either positively or negatively by a simple change in the status of their management.

### State and Local Corrections Health Care

The state and local governments' experience is also worth examining to learn about contracting and its effect on the quality of service. In the general absence of their own medical care facilities and staff, state and local corrections agencies have turned to community hospitals for in-patient care, and to a variety of contracting

arrangements for outpatient services. A national survey sponsored by the National Institute of Corrections (NIC), published in 1984, provides the best indication of the prevalence of contracting--although the picture it presents is now five or six years out of date and provides little detail on the different forms of contracting.<sup>9</sup> The NIC study found that most commonly contracted services were for individual physicians (76% of the surveyed agencies), more general health services (71%), and mental health care (67%). The survey does not permit one to determine how broad the range of contracted services was in each of the jurisdictions, but our cursory review of current contracting, and of the states' history of contracting, suggests that the majority of all contracts at that time were limited to discrete facilities rather than entire systems, and even further to specific types of services (e.g., medical, dental, or psychiatric). A 1985 study of corrections and the private sector sponsored by the National Institute of Justice found fifteen states reporting a "major" contracting program for medical and psychiatric services.<sup>10</sup> Six states reported "modest" programs and another six classified their medical contracting ventures as "minor."

Of interest are the public correctional officials' evaluations of the contracting experience in the NIC survey. The most frequently mentioned benefit was the delivery of a better quality of service (62% of the agencies cited). Providing a unique service not provided by the agency itself was a plus for 24% of the agencies, and 32% cited a decrease in liability by using contracts that improve conditions. The overall advantages of contracting cited by public correctional officials were summarized by the report's authors as including:

- "Complete service at a lower cost"
- "Wide range of expertise"
- "Provides 24-hour coverage"
- "Availability of staff"
- "Professional service"
- "Flexibility in staffing"

On the other hand, agencies also recognized problems associated with contracting. The study did not list these problems separately for health care contracting, but instead reported evaluations of all contracting generally. Of the 161 complaints reported in the survey, the eight most common complaints included:

- Difficult to supervise others' employees
- Poor quality of service
- Did not provide promised service
- Difficulty with bidding process
- Service not provided on time
- Difficulty in regulating service quality

- Having to take low bid and poor quality
- Unsatisfactory payment arrangement

In the absence of more comprehensive published information on correctional health care contracting, Abt Associates solicited information directly from agencies that use contracting to provide comprehensive health care services. Appendix A provides a brief review of those practices in several states contacted in the course of this review. Two conclusions warrant emphasis here.

First, respondents commonly reported that contracting had succeeded in raising the quality of health care. Notably, however, many agencies turned to contracting precisely because their ability to deliver adequate service was exceedingly weak. A pattern of substandard care, federal court intervention, court orders to remedy substandard conditions, and the turn to contracting is found in numerous jurisdictions.

Arguably, if all other things were equal, public corrections agencies might do as well at improving the level of health care service. A second conclusion, however, is that "other things" are not always equal. State and local governments have found it tremendously difficult to recruit and retain qualified health care professionals. Imposing obstacles are often created by the remote locations of correctional facilities, the mismatch between government salary schedules and prevailing market rates, and personnel regulations that constrain flexible employment arrangements. Faced with an imperative to remedy substandard conditions, it is not surprising to find a preference for contracting.

#### **The Bureau of Prisons' Health Care System**

The overall quality of medical care provided by the Bureau of Prisons has not been declared substandard by the Federal Courts, nor is there any other evidence that the system is severely dysfunctional. With the assistance of the U.S. Public Health Service and the use of outside providers on an as-needed basis, the Bureau demonstrates its ongoing ability to deliver a full range of care.

While both independent proprietary hospitals and systems of health care at the state and local level of corrections may have shown improvement under more aggressive private sector management, their baseline levels of service had typically fallen below the floor of acceptable service. Within the context of the Bureau's health care system, there is no reason to believe that a move from public to private status will have either a positive or negative effect on the quality of care.

The Bureau is plagued by many of the same problems of staff recruitment and retention that trouble corrections agencies nation-wide. At its current level of operations, however, there is no evidence that these problems have resulted in unacceptable levels of patient care. Many of those interviewed argued that understaffing is affecting the timeliness of care but not its quality. (The next chapter will discuss the effects of understaffing on the efficiency and costs of the Bureau's operation.)

#### **Staffing Policies and Problems**

As of June 1989, there were a significant number of vacancies in the four referral centers and throughout the national system. Table 5.1 shows the distribution of these vacancies in several categories of health care professionals during that month.

Table 5.1  
Number of Authorized Positions and Vacancies in Selected  
Categories of Health Care Professionals,  
By Referral Center,  
June 1989

	Springfield		Rochester		Lexington		Butner	
	Pos.	Vac.	Pos.	Vac.	Pos.	Vac.	Pos.	Vac.
Physicians:								
Med/Surg	15	4	9	2	6	1	2	1
Psychiatrist	7	3	3	1	2	1	6	3
Nurses	142	15	63	5	31	3	14	4
Physicians' Assts	11	1	12	3	10	3	7	1
Pharmacists	11	6	4	0	4	0	2	1
All positions in referral centers	252	39	133	13	80	11	45	11

SOURCE: For all but Lexington, BPMED18 reports, Bureau of Prisons.  
Lexington data estimated by Mike Lynch, Asst. Health Services Administrator,  
FCI-Lexington.

Understaffing of the referral centers cannot be alleviated by transferring professionals from other parts of the Bureau's medical services division--which is to say, from other prisons--because shortages are even more severe division-wide. During Fiscal Year 1990, the Bureau expects that the division-wide vacancy rate for physicians will be about 47 percent, 73 percent for physicians' assistants, 16 percent for nurses, and about 6 percent for all other categories of health care employees.<sup>11</sup>

Several factors contribute to this pattern of vacancies. There is a nationwide shortage of registered nurses, physicians' assistants, and some types of physicians. Federal funding of the Public Health Service's program of training doctors in return for service at lower pay has dried up, reducing the numbers of "obligated scholars" available to work for low salaries in the Bureau. Recruiting efforts within the Bureau have not been able to compensate for these developments. Civil Service pay scales for several categories of professionals are below market rates, making it difficult to attract and keep qualified people. Working in prisons rather than in free community

hospitals also tends to carry a stigma that hinders further the ability to recruit professionals. Exacerbating these forces at the system-wide level is the difficulty in attracting professionals to the rural locations where many of the federal prisons (but not referral centers) are located.

The highest base salary that can be paid to a physician is currently \$75,000 per year. At present, the average salary is approximately \$71,000.<sup>12</sup> It is possible to win approval to award up to an additional \$20,000 per year to physicians in order to attract them to or keep them in the Bureau, which makes the effective maximum \$95,000 per year. Unfortunately, this is still below what many new doctors hope to make as their starting salaries. According to one recent recruit to a referral center, (who took a cut in salary to come to the Bureau), \$100,000 is the "magic number" for doctors who come out of schools with heavy debt burdens, and they aim to hit that target in their first job after residency. Those medical administrators interviewed for this study were quite uniform in their estimates of salaries that are needed to be competitive: about \$125,000 per year for needed types of physicians. Because psychiatrists can command even more money, one medical administrator thought up to \$150,000 per year was needed to recruit them effectively.

Physicians' Assistants (PAs), are also paid below market rates. The Bureau pays them an annual average of between \$28,900 and \$37,500, while about \$55,000 a year is need to remain competitive with private-sector employers, according to one of the administrators interviewed. Because PAs are in such short supply, according to this administrator, they receive an average of eight job offers upon finishing school, and the Bureau finds it extremely difficult to recruit them with such low salary scales. The time it takes to fill an opening for a PA in the Bureau averages seven to nine months.<sup>13</sup>

Nurses are paid at about the same rate as physicians' assistants, which again is below market rates. The referral center in Rochester recently obtained a special authorization to increase its nurses' salaries by 25 percent, which made it easier to recruit. In addition, the referral center was authorized to permit nurses to work four ten-hour work days a week, which is reported to be the main reason why nurses are staying. Hospitals in the free community are offering a variety of flexible working hours to attract nurses, and the hospital administrator at Rochester believes that even more flexibility than is currently permitted is needed to increase the center's competitiveness.<sup>14</sup>

Lack of flexibility in staffing, because of regulations, also inhibits effective manpower utilization in other ways. For example, hospitals in the free community

maintain "float pools," lists of qualified nurses who are available to work on a part-time or temporary basis. (Indeed, in many hospitals, more than half the nurses on staff are part-timers.) To work even part-time in the referral centers, all Bureau employees are required to attend the training academy in Virginia for a month. Unable to make this commitment, usually because of family obligations, potential part-time nurses are blocked from working in the referral centers.

The referral centers also cannot hire consultants full-time to fill the gaps in their staffs because of the government policy restrictions. To do so would create a second tier of full-time employees, each having different salary and benefit structures. As a result, the referral centers hire many different consultants on a part-time basis, paying their high "market" rates (as much as \$150,000--\$300,000 a year). Some of this is unavoidable, because certain types of specialists are needed too infrequently to justify full-time employment in the Bureau. For other types of physicians (such as internists, for example), it might be more cost-effective to employ them full-time at a higher annual wage than they can currently be paid, rather than buy their services piecemeal.

Finally, some hospital personnel argued that the true measure of understaffing at the referral centers is not the gap between the number of authorized and filled positions, but between the number of filled positions and the number that is needed to provide services at the standard that prevails in the free community. For example, one administrator at Rochester argued that the needed number of nurses at that referral center was not 63, as authorized, but closer to about 110 or 120. Asked how the current number of authorized positions was determined, several administrators said that they simply estimated how many professionals of all types would be needed to staff such a facility, and that they are now having to adjust their decisions with the benefit of experience. They emphasized that the level of services was not now so low as to risk their accreditation status or to raise liability problems, but suggested that it fell "somewhere between the minimum level and the community level."

#### **A Cautionary Note on Using Contracting to Resolve Staffing Problems**

To be sure, a policy of contracting for all or most of the operations of the Bureau's health care system might alleviate the quality-related constraints imposed by federal personnel regulations and pay restrictions. But a policy of sufficient scale to solve these personnel problems raises problems of its own:

### Stability

The threat of disruptions in service by virtue of strikes and bankruptcies becomes more worrisome the more reliant an agency is on contracting. It is also important to ask whether a large program can be sustained in the long term, and whether there will be a sufficient number of provider organizations to avoid the creation of contractor monopolies and a diminution of the benefits of open-market competition.

### Reversability

The larger the contracting program, the less reversible the decision. Even if the government retains its ownership of facilities and equipment, restaffing may be difficult. An already constrained public personnel pool will be even more limited, and there may be a long lag time before new personnel can be recruited and trained.

### Quality Assurance

The key elements of effective quality control are deceptively simple: (1) A contract that clearly specifies all expectations, incorporating measurable indices of performance; (2) payment provisions that create incentives for efficiency without simultaneously offering disincentives to maintain standards of care; and (3) rigorous monitoring procedures designed to identify and establish the means for resolving problems. Applying these tenets in a health care setting is extremely difficult. The available standards--most notably those of JCAHO--are necessarily procedural, not substantive. Ultimately, the provision of appropriate patient care relies on the informed judgments of an array of professionals whose decisions are difficult to codify and hard to regulate. Monitoring these decisions requires sensitive information systems and well-trained health care professionals who can adapt to their new supervisory roles. Both the costs of this additional layer of supervision and the uncertainties that surround the monitoring task suggest that careful pilot testing would be essential before any large scale implementation.

Obviously a decision to contract a single, privately operated facility involves far less risk. The Bureau would be less vulnerable to disruptions in service and better able to recover from a contractor withdrawal or termination, or to test and refine an appropriate quality assurance program. While a single facility fails to address the problems of system-wide personnel shortages, it may, if successful, serve as a useful laboratory, or even an exemplar, providing other institutions in the system with a benchmark for self-evaluation.



By the same token, however, the ability to integrate a single, privately managed institution into the Bureau's health care system could prove troublesome. Creating a dual system of health care service--with conceivably different pay scales for its public and private components--might exacerbate public sector recruitment and retention problems. Salary caps on contractor's employees are an obvious solution but one that might perpetuate inefficiency or dilute standards of care, or even defeat the contractor's ability to hire staff.

If, as a matter of policy, a test of private management is considered desirable, a highly specialized facility might serve critical Bureau needs, at the same time minimizing the danger of creating a two-class system of health care. The preceding chapter suggested that the Lexington referral center for female inmates might provide a logical testing ground for a privately managed facility. Another possibility for specialization might be a facility for inmates with AIDS and other illnesses requiring long-term care. Chapter I has already commented on the "graying" of the nation's prison populations. This phenomenon has substantial health care implications, given the incidence of chronic health problems among elderly prisoners.<sup>15</sup> Combined with the threat of increasing numbers of prisoners with AIDS, the demand for a long-term care facility may soon rise.<sup>16</sup> In order to build sufficient demand to reach advantageous economies of scale in the near term, such a facility might take prisoners from various state jurisdictions that also face problems of scale in coping with inmates with specialized needs for medical care.<sup>17</sup>

Whatever the population to be served, the point remains that a means to differentiate the public and private component of the Bureau's health care system seems desirable, if not essential. Since the interest in the private sector in any prison hospital venture has yet to be tested, it is unclear whether a procurement targeting cases in need of long-term care (including AIDS cases) would find a receptive audience. Because there is no evidence that privatization will necessarily raise the quality of services, the risk of potential disruptions and other negative consequences on the broader system might not be worth it, on balance, unless there are clear advantages in specialization, efficiencies, or lower costs to be gained.

## Endnotes

1. Bradford H. Gray (ed.), For-Profit Enterprise in Health Care, a report of the Institute of Medicine (Washington, D.C.: National Academy Press, 1986).
2. Gary Gaumer, "Medicare Patient Outcomes and Hospital Organizational Mission" in Gray, For-Profit Enterprise, pp. 354-374.
3. Gray, For-Profit Enterprise, p. 189.
4. Ibid.
5. Stephen M. Shortell and Edward F.X. Hughes, "The Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital In-patients," The New England Journal of Medicine, April 18, 1988, p. 1100-1107.
6. R.A. Musacchio, et al., "Hospital Ownership and the Practice of Medicine: Evidence from the Physician's Perspective," in Gray (ed.) For-Profit Enterprise, pp. 385-401.
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9. Camille, G. and George M. Camp, Private Sector Involvement in Prison Services and Operations (South Salem, NY: Criminal Justice Institute, 1984).
10. Joan Mullen, et al., The Privatization of Corrections, (Washington, D.C.: U.S. Department of Justice, National Institute of Justice, U.S. GPO, February 1985).
11. Interview with Steve Dann, Chief of Operations, Bureau of Prisons Medical Service Division, August 10, 1989.
12. Ibid.
13. Ibid.
14. Jeanne Smith, (Health Services Administrator, Rochester referral center), November 1, 1989 interview.
15. "Experts See Growth in Elderly Inmate Populations," Criminal Justice Newsletter, November 15, 1989, pp. 5-6.

16. Seroprevalence studies of males and females conducted by the Federal Bureau of Prisons show the following results reported in Hammett, 1988 Update: AIDS in Correctional Facilities, U.S. Department of Justice, National Institute of Justice (Washington, D.C., U.S. GPO) April, 1989.

<u>Number Tested</u>	<u>Inmate Categories</u>	<u>Number HIV Seropositive</u>	<u>% Seropositive</u>
9,640	all incoming inmates (6/87-10/87)	240	2.5
23,172M 1,887M	all releasees (6/87-12/88)	393M 24F	1.7M 1.3F
5,239M 935F	10% random sample of incoming inmates (11/87-12/88)	129M 49F	2.5M 5.2F

As of October 1, 1988, the Bureau reported the following confirmed AIDS cases:

Deaths	77
Releases	51
In System	48
Cumulative Total	<u>176</u>

As of October 1, 1989, this distribution had changed as follows:

Deaths	97
Releases	51
In System	<u>57</u>
Cumulative Total	<u>205</u>

17. The distance factor is a primary problem in designating a single facility for long term care of inmates from various federal and state jurisdictions. Removing severely or terminally ill inmates from their home jurisdictions would necessarily distance them from their families.

## CHAPTER SIX

## ALTERNATIVES TO CONTRACTING FOR MANAGEMENT OR OPERATIONS

Turning to private management firms is but one strategy that might be adopted in the quest of gaining stronger control over the utilization of healthcare resources and their costs. In the course of our research, other possible approaches became apparent. This section suggests directions that the Bureau might explore whether or not the privatization option is pursued for any or all of the referral centers.

**Alleviating Staff Shortages**

As discussed in Chapters Two and Five, the ability to treat patients efficiently within the referral centers appears to be constrained by staff shortages. These shortages will become more severe in the coming years with the cessation of funding for Public Health Service scholarships (which oblige newly-minted doctors to work at reduced pay in government hospitals). Faced with similar labor problems, some states have turned to contracting in order to obtain sufficient staff. One significant reason why contractors are able to hire more staff is that they are able to pay them more than is allowed by the state pay schedules. A more direct way of solving the recruitment problem would be to raise compensation levels. At the federal level, the most feasible method of accomplishing this might be to increase the size of the compensatory bonus that may be awarded physicians. There also may be other ways of affording physicians additional benefits that would attract them to prison service, such as providing them with additional training in their specialties.

Another possible approach to alleviating the physician shortage is to enter into an affiliation agreement with nearby medical schools and teaching hospitals. This has been the method used by public and VA hospitals to improve their services. This would afford prisons a cheap source of clinical labor. Medical schools would gain because it would expose students to different types of health care needs. To be sure, some security issues would be raised, but these do not seem insurmountable.

The Bureau also could do a more effective job of recruiting staff. Several of those persons we interviewed indicated that they were unable to do as focussed a recruitment effort as they would like. At present, the burden for recruiting is on the medical directors at the referral centers. Creating a specialized recruitment capability at the national level might increase the provision of healthcare workers without any other changes in compensation.

### More Efficient Use of Resources

The utilization of referral center resources is affected by procedures for referring patients to them, by in-hospital management of their cases, and by procedures for discharge. Efficiency gains might be obtained by changes in each of these three areas of practice.

#### Rationing Referrals to the Centers

On site visits to the referral centers, we heard stories of prisoners with relatively minor and easy to repair health problems being transferred to a referral center when it could have been cheaper to have the procedure done locally in a nearby community hospital. How often this occurs is impossible to estimate because data are lacking. In the past, an incentive to make such decisions was created by giving superintendents at each federal prison a budget for transportation and another for purchasing local health care. If more money happened to be left in the transportation than in the latter budget, an incentive was created to send the prisoner to a referral center in order to preserve funds in the health care budget, even if the procedure could have been done locally at a low cost. This disincentive to obtaining local treatment was reportedly eliminated by consolidating the two budgets into a single one.

There remains, however, another incentive to use referral center resources instead of purchasing local care because the referral center appears as a free resource to the prison superintendents—who are consumers in the Bureau's healthcare system by virtue of their authority to decide where treatment will be provided. Indeed, the referral centers are "free" if they are in operation, staffed up, and have unused capacity. (That is, a large part of their operating cost is fixed, and the marginal cost of servicing each additional prisoner is quite low, at least until capacity is reached.) Transfer to a referral center may indeed be economical in these conditions, if the cost of transportation and the marginal cost of treatment at the referral center is lower than the cost of treatment in a nearby community hospital.

This practice becomes inefficient, however, when the referral centers' capacity is reached, and when the transfer of such cases forces other patients into nearby community hospitals for lack of space. At present, the referral centers are operating close to their full capacity. For example, in June 1989, it was reported that the waiting time for non-emergency cases was three to four weeks. Moreover, it was reported that in May, only 253 prisoners who requested transfer into the referral

centers were accommodated, out of the 332 making such requests.<sup>1</sup> The remainder were sent to community hospitals.<sup>2</sup>

If a large group of those currently treated in referral centers could have been treated for less than the per admission costs shown in Table 2.1, it might be more effective to ration the use of the referral centers, reserving them for the most expensive kinds of treatment (and for high-security inmates), and sending more prisoners to local community hospitals. If the referral centers generated patient-specific and treatment-specific cost information, administrators and planners would have the ability to compare referral center costs with prevailing charges by community hospitals, and could then determine more rationally which prisoners might be more cost-effectively treated in community hospitals than at the referral centers. At present, such information is not collected.

This information would also be useful in planning for expanded capacity. Coupling computerized data on patient characteristics and treatments would enable one to assess how many of the existing referral centers' patients might be more efficiently distributed among referral centers and community hospitals. This information could then be used to extrapolate needed prison hospital capacity at higher levels of federal prisoner populations.

An even more radical but potentially productive approach would be to create a billing and pricing system, so that the cost of specific in-house services could be readily communicated to potential users (or the health services administrators and wardens acting on their behalf). This would increase the ability to discriminate efficiently between the cost of in-house treatment and the cost of services in nearby hospitals. By limiting the funds that prison superintendents have for healthcare services (and requiring them to pay for referral center treatments out of their budgets) an incentive to economize would be created.

The ability to use local community hospitals rather than transporting prisoners to referral centers might be further enhanced by expanding the infirmary capacities at the prisons--especially the larger ones--so that room for convalescing is created. Whether or not such an expansion would be economical, and at what scale, is deserving of further study.

### Stratification of Caseloads

Another strategy for increasing the productivity of the referral centers that holds promise are the procedures the Bureau is establishing to "stratify" the delivery of health care in the referral centers. Resources and coverage are being reorganized so that they are concentrated on those patients most in need, and reduced for less needy patients. This strategy should reasonably be expected to result in more efficient operations. The current efforts should be evaluated closely, which will require developing better data and data management systems with information on expenditures, utilization of resources, treatments provided, and patient diagnoses.

Stratification could be coupled with the creation in some referral centers (and expansion in others) of "step-down" units in which prisoners are placed to convalesce. Because these do not need to be staffed so heavily, they are less costly to operate than full-service hospital wards. Wings of existing referral centers could be so designated. Under present conditions of near-full capacity, the possibility of building convalescent units on the grounds of existing referral centers, or nearby, should be explored as an alternative to acquiring or building additional referral centers.

### Creating Incentives for Quicker Discharge

As discussed in several places in this report, the lengths of stay in the referral centers are very long, on average, and could be shortened. In addition to the various other strategies discussed above and elsewhere (e.g., alleviating staff shortages), the Bureau's managers might well consider how incentives might be created to speed treatment and processing of patients. Faced with accusations of inordinately long stays, the VA began several years ago to use DRGs as targets for appropriate lengths of stay. Setting targets, and devising incentives to encourage staff to meet them, might yield useful results, and lower per admission costs, in the Bureau's referral centers.

### Better Data for Efficient Management

All of the strategies for improvement discussed here require information and information systems. Managing resource utilization efficiently is difficult in the absence of information about how resources are being used and how much they cost. The Bureau would be well-advised to create a capability for effective reviews of resource utilization.

At present, the Bureau's ability to conduct such treatment-specific analyses of costs, and to analyze utilization data, are underdeveloped. Utilization data are reported on paper forms, and it appears that there is a lack of consistent counting rules for reporting data. Some referral centers are beginning to develop their own computerized data bases for patient information, but this developemnt threatens to balkanize the Bureau's ability to achieve a uniform data base and reporting system. Given the increasing complexity of managing the Bureau's health care system, and the certainty of much higher expenditures in the coming years, investment in the development of automated data bases for a variety of utilization and cost data would undoubtedly pay large dividends. A contractor hired to administer a referral center might be required to develop a prototype of such a system in the single referral center, but a wiser strategy would be to undertake development of a Bureau-wide system at once. This could be done by contracting with a firm having expertise in developing just such systems.



## Endnotes

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APPENDIX A

STATE AND LOCAL EXPERIENCE WITH CORRECTIONAL HEALTH CARE  
CONTRACTING

## APPENDIX A

STATE AND LOCAL EXPERIENCE WITH CORRECTIONAL HEALTH CARE  
CONTRACTING

Contracting for correctional health care has been most extensive at the state and local government level, where corrections agencies have relied for years upon the private sector to provide services. Contracts with private firms are used almost exclusively for out-patient care. When inpatient care is required, correctional agencies generally transfer prisoners to local community hospitals. Some localities, because of the high demand in the correctional systems for inpatient services, have arranged with these local hospitals to maintain secure wings used exclusively by prisoners. A few jurisdictions have small hospitals, usually secondary-care facilities that have very limited capabilities for handling patients needing acute care. In most places, correctional agencies purchase standard-issue inpatient beds on an as-needed basis, and post security officers near these inmate patients to guard them while they are in the hospital.

As discussed in Chapter Two, the available data on correctional health care contracting are highly fragmentary and somewhat dated. To obtain a more current view of state and local experience, information was solicited directly from several major users of health care contracts. Most jurisdictions contract for specific services, often by specific individuals, as the 1984 NIC survey of state governments indicates.<sup>1</sup> That is, they may purchase the on-going services of individual physicians, psychologists, pharmacists, dentists, or other care providers. Or they may buy broader "packages" of care--e.g., all mental health care in a particular facility. Because the Bureau of Prisons' referral centers already purchase the services of a number of contractors--typically, individuals or nearby hospitals--we have chosen to focus our examination here not on state and local experience with such piecemeal and limited contracting but instead on the places where correctional agencies have hired firms to provide more comprehensive and managed care. This is more likely to tell us about the advantages and disadvantages of contracting for management services in correctional health care settings. Below is a discussion of three of the most interesting and relevant cases (practices in Arkansas, Georgia, and Massachusetts).

## Contracting in Three States: A Brief Illustration of Some General Practices

### Arkansas

This state's Department of Correction has an average daily population of about 6,000 in nine major prisons and and three work-release facilities.<sup>2</sup> Since 1981, one firm has provided comprehensive medical and associated administrative services and supplies to all prisoners in the system. These include those housed in cellblocks (i.e., outpatients), those in small infirmaries having a few beds, prisoners receiving in-patient care purchased from local hospitals (the costs for which the contractor is responsible), and prisoners housed in or passing through the 24-bed Diagnostic and Inpatient Care Facility. This facility provides outpatient care, including physicals, as well as pre/post-surgical care and recovery, convalescence, and chronic care. It is essentially a skilled, non-acute care unit. The contractor is responsible for negotiating the agreements and relationships with local hospitals to which prisoners are sent for inpatient services. (The contractor does not provide either dental or mental health care.)

The contractor has the responsibility of managing the medical care of prisoners, from outpatient through inpatient services, within a negotiated budget. The cost of the services is established by a bidding process whereby bidders offer assessments of what it will cost to provide a list of services to a specified number of inmates, at a per inmate/month rate. The Arkansas Department of Correction reviews the assumptions followed by the contractors in developing their estimates, and chooses the winning bid on the basis of cost, strength of staff, and other aspects of the contracting firm. The contractor is paid monthly, the amount based on the average daily population of prisoners, multiplied by the established "inmate per month cost factor."

The Department pays all medical bills and then settles at the end of the month with the contractor. Costs that run over the established monthly amounts (determined in the manner described above) are deducted from future payments to the contractor. In this manner, the contractor is at risk for overspending, although in the case of some extraordinarily high costs, the contractor and the department meet to determine how these high costs are to be shared. Through 1988, the contract limited the contractor's liability to \$35,000 per inmate. This was changed in 1989, when the department agreed to be more flexible in sharing extraordinary expenses on a case-by-case basis.

According to the chief administrator for the state's Department of Correction, the services provided by the contractor could be provided directly by the state for about 13 percent less--the amount the contractor charges for its fee and overhead expenses.<sup>3</sup> This is, at best, an opinion rather than a substantial finding, because no systematic study has been done comparing the costs and benefits of direct provision and contracting. Despite the appearance of a higher cost of contracting, the Department reportedly feels that the arrangement is preferable to direct provision of services because of three principal benefits. First, the department's managers achieve a sharper focus by delegating management of medical care to a contractor. (That is, by delegating to private specialists the day-to-day management decisions involved in running health care facilities, they are able to devote a greater portion of their time both to the core mission of the agency--secure corrections--and to the end products of the health services.<sup>4</sup>) Second, the department is limited by state personnel regulations in its ability to hire health care workers at market rates and to be as flexible as the contractor is in scheduling coverage and assigning staff. Third, the department believes that it is reducing its exposure to inmate lawsuits because both the inmates and the courts apparently perceive that they are getting better care than the department would be able to provide directly. One of the department's officials summed this up by the saying that the "Department should not attempt to force the costs lower and run a program which loses credibility . . . and winds up costing more in the long run."<sup>5</sup>

#### Massachusetts

The Massachusetts Department of Correction operates 22 prisons, with about 7,600 prisoners, not counting prisoners in addiction centers and mental health facilities. Like Arkansas, the state contracts with a single firm (a not-for-profit corporation) to provide all medical services to prisoners in all facilities. The contractor also provides mental health services in addition to medical, and it operates and manages the state's correctional psychiatric facility, Bridgewater State Hospital. (Dental services are provided by consulting dentists rather than by the contracting firm.) Except for the management of the psychiatric hospital, all medical services are for outpatients in the prisons. If inpatient medical or surgical care is needed, the contractor's physicians notify the Department of Correction's officials and those officials arrange a transfer either to a nearby community hospital, in the case of emergencies, or to secure wing of an underutilized state hospital in Boston, which provides the department with all inpatient services "free." (That is, the costs are

covered by the state's Department of Health rather than by the Department of Correction.) The contractor is not at risk, therefore, for expenses incurred for inpatient treatment.

As in Arkansas, the cost of contracted health care is reportedly higher than it would be if provided directly. The department's associate commissioner in charge of health services estimates, with a "wild guess," that the department could provide the services for perhaps 10-15 percent less than the contractor charges, but argues that the benefits received outweigh the higher costs. The principal one is that the contractor is not bound by the state's personnel regulations and non-competitive pay scales and is therefore able to hire higher quality staff in the required numbers.<sup>6</sup> To staff the facilities, the contracting firm makes extensive use of part-time physicians, nurses, and physician's assistants; permits staff wide latitude in choosing week-to-week work schedules within constraints imposed by agreed-upon coverage requirements (with flex-time, comp. time, etc.); and offers higher pay on an hourly basis than could the state. Both the contractor and the department's administrator believes that this flexibility and use of part-time employees reduces employee "burnout" that occurs when professionals work only in prisons, improves retention, and permits more use of high-skilled professionals.<sup>7</sup> The administrator also stated that the higher level of care translates into fewer lawsuits against the state.

The contractor is reimbursed for costs incurred. The winning firm is chosen on the basis of its estimated price for providing services specified in the state's RFP (in addition to other qualities of the firm and the firm's proposal). Because all contractors with the state of Massachusetts are regulated by the state's Rate Setting Commission, line-by-line expenses are given close scrutiny and are subject to fixed limits. In such a regulated environment, the contractor is given only limited management autonomy to organize health care provision, and the firm's exposure to risk is minimized.

### Georgia

The Georgia Department of Corrections (DOC) is comprised of 25 correctional facilities and is responsible for approximately 13,700 inmates.<sup>8</sup> Rather than contract for all medical or health care at all the state's prisons, the department provides service directly where it can do so successfully, and contracts for service to prisons that are in remote areas or are under federal court orders. (Federal court pressure was a major factor in choosing to contract.) Since 1980, the department has been contracting with one firm, which receives about thirty percent of the department's \$30 million

correctional health care budget, to provide services in 12 DOC facilities, which altogether hold approximately 50 percent of the system's inmate population.<sup>9</sup> Two contractual agreements exist. The first is for the provision of medical personnel at ten of the twelve facilities. An RFP was issued by the DOC listing the administrative and medical positions they wanted filled and offering a flat rate at which the personnel would be paid. The second contract is cost-based and is for the provision of personnel as well as for the management and delivery of health care in two facilities, a large prison infirmary and the Augusta Correctional and Medical Institution (ACMI), a 135-bed care facility that operates as the main referral center for the department. The contractor is paid on a per-inmate basis, at the annual rate of \$1,625 per inmate for fiscal year 1989.<sup>10</sup> This second contract leaves the responsibility of health care provision to the contractor, thereby permitting the contractor to determine the number of personnel necessary to fulfill the terms of the contract.

The experience of ACMI will be especially interesting to watch because it is one of the few state or local correctional hospitals in existence. Until recently, it was only a 135-bed infirmary on the site of a 600-bed prison that provided primary health care to prisoners in the facility and served also as a focal point for coordinating the delivery of secondary and tertiary care to prisoners referred there from all prisons in the state. Until the spring of 1989, all surgical work was done outside the department, at the Humana Hospital in downtown Augusta. The state has just completed construction of two surgical suites at ACMI, however, and the contractor is obliged to staff and manage this part as well. According to the contract, the state expects as many as 600-750 procedures, primarily general surgery, orthopedic and ENT but not tertiary-level procedures that will still be done at Humana.<sup>11</sup> The organization of this facility approximates the structure of the Bureau of Prison's referral centers. It will consequently be important to evaluate within a year or two to identify how effectively private firms are able to manage government-owned prison hospitals.

In addition, the department is experimenting with another type of contract at the Lowndes Correctional Institution, one of its prisons in the town of Valdosta. The same contractor that provides the services described above was asked to establish a comprehensive health care program at the facility, and a pilot project was undertaken. Under this agreement, the contractor pays for all health care costs, including drugs, and outside medical consultations and procedures, for a fixed price, established on a per-inmate basis. The state plans to evaluate this within a year or two to see if this

broad delegation of management provides an effective model for health care provision within the prison system.<sup>12</sup>

The department's health care administrator reports that the direct costs of contracting for health care are higher than they would be if the state provided services directly, but that "the indirect cost of litigation and staff hassles probably make contracting cheaper in the long run." Further benefits include the contractor's ability to do national recruitment that results in hiring more and better staff than the department would be able to do on its own. Hiring and firing of employees is more efficiently accomplished because the contractor does not have to adhere to the state's personnel regulations, and the quality of care provided is high. Indeed, the contractor met the standards established by the federal court fourteen months before the deadline.<sup>13</sup>

### Some General Themes in the State and Local Experience

Extracted from our studies of these and other cases, a number of relevant themes emerged. Although we make no claim that our sample is either comprehensive or representative, it does seem possible to articulate some very tentative generalizations. Below is a short list of the more relevant findings.

#### Cost

Those correctional department officials interviewed in many of the states reported that contracting for health care is more costly than direct provision. Lacking the ability (and the accounting methodologies) to undertake sophisticated cost comparisons between public and private provision, most officials made "wild guesses," as one called his, about what the cost difference is likely to be. Others made some guess about what the contractor's overhead charges were likely to be, or their profit margins, and felt that these indicated the probable difference. For two reasons, these estimates should be read with caution. First, it is extremely difficult to identify the true costs of government service. Because many costs may be spread across different agency budgets and government overhead accounts, public officials may be judging comparative costs against an inaccurate standard. Second, the comparisons tend to make assumptions about other things being equal. That is, the cost of Massachusetts providing the same services directly would be X percent lower than the contractor's price. But this puts no value on the contractor's being able to provide the level of service in the first place, and correspondingly ignores the state's inability to bring



staffing or services up to the contractor's level. The real comparison is between the cost and value of the contractor's services, and what the government agency would pay and deliver in the absence of contracting. Agency officials in many jurisdictions generally recognize this, and chose to bear what they perceive to be the higher cost precisely because they are unable to provide the services themselves at acceptable levels.

### Improved Services

A common report in the interviews was that contracting has succeeded in raising the level of correctional health care. Tennessee's women's prison kept failing a mock ACA audit of health care services until they contracted with a national firm. Within a few months of signing the contract, the actual ACA audit took place and the medical care section of the facility scored a 99.6, and the institution earned accreditation.<sup>14</sup> Health care in Kansas prisons has improved dramatically.<sup>15</sup> Correctional administrators in the New York City jail system report being so pleased with the contractor's services in one jail that the agency chose recently to contract in all jails.<sup>16</sup> In both Georgia and Delaware, the performance of the contractors has exceeded the requirements established by the states.<sup>17</sup> In some states, however, there have been lawsuits alleging gross negligence in the care of patients. (For example, in Massachusetts, the contractor operating the Bridgewater State Hospital has been sued for gross negligence<sup>18</sup>.)

Some states reported past difficulties with contractors' performance, but the typical method of resolving this was to award the contract to another firm.<sup>19</sup>

### Could the Public Sector Do As Well?

Many states and local governments turned to contracting because their ability to deliver the service was exceedingly weak. One of the earliest local contracting relationships was struck between New York City and Montefiore Hospital in 1973 because it was thought, according to two observers, that "one cause of the riots of 1970 [in the large New York City jail system] was the disastrous status of prison health care; the quality of care must be maintained . . . in order to avoid similar occurrences."<sup>20</sup> Kansas began contracting in 1988 because prior to that, there was almost no prison health care system to speak of in the state, and the "rudimentary" state of health care had become increasingly unacceptable. A federal court order required that the system be reformed, and the state turned to a contractor to implement the court's demands.

Under contracting, the quality of health care services in the state prison system have gone from "virtually nil to steps towards ACA accreditation."<sup>21</sup> As indicated above, both the Arkansas and the Georgia systems were also under federal court orders, and contracting was chosen as a means of bringing their health care systems into compliance. This pattern of substandard care, federal court intervention, and the turn to contracting is found in numerous jurisdictions.

Improvements in health care have not always required the involvement of private sector firms. A recent article discusses three state systems (Illinois, Michigan, and Texas) that undertook major changes in their publicly managed programs.<sup>22</sup> In each case, the impetus for reform was the same threat or reality of litigation. But with aggressive public sector leadership, these states reportedly made significant improvements without turning to private sector management. What appears to be required is the recognition that change is needed, and the commitment to support improvement--regardless of whether a public or private agency is selected to implement the reform.

### Obstacles to Staffing

In one arena, the private sector does offer a clear advantage. Faced with a nationwide problem--the shortage of physicians, nurses, and other health care professionals, and the difficulties in attracting them to remote areas of the country--state and local governments have had difficulties in recruiting these professionals. Contractors claim that they bring special expertise in recruiting health care professionals and that they can rely upon a national network. The experience in a number of states suggests that at least several contractors can deliver on their promises. (One nationally-oriented contractor reported that they recruit nurses in areas where there are either surpluses--in Canada, for instance--or in economically depressed areas where nurses' salaries are low.)

A more imposing obstacle is the mismatch between government salary schedules and market rates for health care professionals. Moreover, the constraints on changing these schedules in many states are so restrictive that it is easier for a departmental administrator to turn to contracting than to try to get government salaries raised. For example, the salaries paid to state health care workers in Massachusetts' Department of Correction are established for all positions within a bargaining unit that encompasses the state's Department of Health. Because medical professionals in the prisons would be assigned by the Department of Health, the salaries

of those in prisons could not be negotiated upwards without raising the salaries of all positions within the broader bargaining unit.<sup>23</sup> To a decision-maker sitting in a line agency, trying to accomplish a "simple" raising of salaries must appear to be a task far more formidable than choosing the easier path--to contract for these services in order to bypass state personnel regulations and pay restrictions.

In addition to sub-market salaries, administrative restrictions on flexible staffing arrangements put many government agencies at a comparative disadvantage in the hiring market. Liberated from personnel regulations, contractors can make much more creative use of part-time employees. In Massachusetts, for example, the state-wide contractor attracts well-trained psychiatrists and psychologists who are beginning to build their private practices. The employment agreement is flexible enough to let these persons cut back their prison work progressively, over months or years, as their private practices grow. The contracting firm also employs physicians who want to moonlight by being on call during evenings for emergencies.

### **The Importance of Incentives**

The contractual arrangements that appear to have the greatest capacities to control costs are those that establish a price for delivering comprehensive health care--from primary through acute--and put the contractor at risk of losing money if they fail to keep costs down. The experiment in Georgia's Lowndes Correctional Institution is an especially interesting example of this. Cost-reimbursement contracts such as those in Massachusetts may create fewer incentives to control costs.

Asking a contractor to provide health care for what amounts to a fixed price, given the prospects of catastrophic illness or injury, or of AIDS, poses an obvious problem. How is the impossible-to-foresee case that costs hundreds of thousands of dollars to be insured against? One possibility is to require contractors to cover all potential costs, thereby creating the most demanding incentives for cost control. The contractor's options in such a case are to either purchase an insurance policy against such a possibility from a third party, or to self-insure by fixing a price for services that is high enough to build up a large reserve.

Another option is for the contracting agency to insure the contractor against such events. One method found in some states is a to fix a specified cap on the contractor's liability. The state of Tennessee, for example, requires the contractor to pay for all treatment but limits liability to \$12,500 per inmate, or \$25,000 for incidents involving multiple inmates. Costs exceeding these amounts are paid by the state. In

addition, the contractor is not liable for AZT treatment or its successors, or for hospitalization for AIDS. (Hospitalization for AIDS-related complexes must be paid for by the contractor, however.)<sup>24</sup> Other states have variations on this theme, setting liability caps at different levels, with different types of exclusions for very expensive treatments.<sup>25</sup>

Tennessee has also developed an interesting contractual structure that creates incentives both to control costs and to assure an adequate level of services. Half of the contract is essentially of the cost-plus-fixed-fee variety, and the second half establishes a fixed price. Services provided on a cost-plus basis include all costs of operating outpatient clinics and infirmaries, including salaries, fringe benefits, office supplies, travel expenses, and so forth. The state reimburses the contractor for all costs incurred for these services and pays the contractor another 10 percent as a fee. This permits the state to avoid paying if demand drops off and costs go down as a result. Further, the contractor is not at risk if demand increases more than expected. But because the state wants to control the cost of outside hospitalization, dental services, and pharmaceutical supplies, payment for these is at a negotiated fixed price. (There are some limits on the contractor's liability, as discussed above.) This fixed-price tier of services creates powerful incentives for the contractor to control their use and to negotiate favorable purchasing agreements. According to the department's health services administrator, the state is "exceptionally happy with the arrangement and the service to date." It is, in his words, an "exceptionally successful program." Prior to signing the contract, for example, the state was spending about \$90,000 a year for drugs at the women's prison. Now the contractor is reportedly spending about \$32,000 per year. The contractor "can be a lot tougher with the inmates than our people can." "Our people tend to pass out drugs for the placebo effect, whereas their people are much more restrictive." Similarly, the cost of medical services at the women's prison has dropped from an average of \$90,000 per month to \$62,000 per month.<sup>26</sup>

In considering these reported savings, it is important to recall that comprehensive data on the overall costs of public vs. private operations were not available and could not be generated for this review. More detailed study is required before any firm conclusions can be reached on the question of relative costs.

## Endnotes

1. Camille G. Camp and George M. Camp, Private Sector Involvement in Prison Services and Operations (South Salem, New York: Criminal Justice Institute, 1984).
2. Most of the information that follows was provided by John Byus, Administrator of Medical and Dental Services, Arkansas Department of Correction, in several telephone interviews during July 1989.
3. Ibid.
4. For a discussion of privatization and managerial focus, see Michael O'Hare, Robert Leone, and Marc Zeagans, "The Privatization of Imprisonment: A Managerial Perspective," in Douglas C. McDonald (ed.), Private Prisons and the Public Interest (New Brunswick, N.J.: Rutgers University Press, forthcoming).
5. Internal memorandum by Max J. Mobley, Arkansas Department of Correction, 14 February 1989, p. 2.
6. Frank Jones, Associate Commissioner, Massachusetts Department of Correction, interview, July 1989.
7. Interviews with Frank Jones and Dr. Ronald Goldberg, President of Goldberg Associates, July 1989.
8. American Correctional Association, 1989 Directory, (Laurel, Maryland: American Correctional Association, 1988), p. xxii, pp. 112-16.
9. Ibid.
10. Ibid.
11. State of Georgia, Request for Proposal Number 467-080-301739, dated 21 December 1987.
12. Michael Spradlin, Administrator of Health Services, Georgia Department of Corrections, telephone interview 9 May 1989.
13. Ibid.
14. George Jungmichael, Assistant Director for Fiscal Services, Tennessee Department of Correction, telephone interview dated 11 May 1989.
15. Nadine Belk, Kansas Department of Corrections, Health Services Administrator, telephone interview, 26 June 1989.
16. Steven Thomas, Assistant Commissioner for Planning and Health Affairs, NYC Department of Corrections, 21 July 1989 interview.
17. Spradlin interview; Brooke Laggner, Chief of Administration and Operational Support, Delaware Department of Correction, telephone interview dated 2 August 1989.

## Notes, continued

18. Memorandum from Professor Mark Schlesinger of Harvard University, 9 January 1990.
19. In Arkansas, for example, according to interview with John Byus, Administrator of Medical and Dental Services, Arkansas Department of Correction, 12 July 1989.
20. Louis Medvene and Carol S. Whelan, "Prison Health Care in New York City: A Historical Perspective" (New York City: Community Service Society, May 1976), p. 1.
21. Nadine Belk, 26 August 1989 interview.
22. Peter MacPherson, "In a Padlocked Society, Good Health Care Remains an Elusive Goal," Governing, April 1989, p. 50-54.
23. Frank Jones, July 1989 interview.
24. George Jungmichael interview.
25. Delaware, for example, fixes the limit at \$15,000 per prisoner, according to Brooke Laggner, August interview. Kansas' limit is \$10,000 per prisoner. Nadine Belk, 26 August 1989 interview.
26. Jungmichael interview.

APPENDIX B  
COMPUTATION OF  
REFERRAL CENTER EXPENDITURES

Table B.1

Estimating Average Per Capita Daily Cost  
of Inpatient Health Care In Four Major Referral Centers, FY88  
(Excluding Estimated Costs of Outpatient Care to General Population)

Step 1: Estimating average daily per capita cost of narrowly defined "medical" care, excluding estimated cost of outpatient care to general population (\$2.60 per prisoner)

	Medical	Outpatient Care	Inpatient Care	PHS	Number of Patient Days	Average Cost Per Patient
Lexington	\$6,008,881	\$1,172,423	4,836,458	\$534,142	24,487	\$219.32
Butner	2,046,181	573,503	1,472,678	337,704	56,749	31.90
Springfield	12,281,602	290,087	11,991,515	785,161	257,820	49.56
Rochester	7,036,880	481,328	6,555,553	594,831	44,129	162.03

NOTE: "Medical" is defined as all costs in Decision Unit B (DUB), in the Bureau's accounting system, minus an estimate for cost of care given to outpatients. (For the assumptions used in estimating this per-outpatient cost, see Table B.2 below. The total est. cost of outpatient services was computed by multiplying estimated outpatient/day costs -- \$2.60 -- by the difference between total man/days, below, and total number of patient days.) "Inpatient Care" (the total estimated Bureau of Prisons expenditure for inpatient care) equals the total medical/DUB expenditure minus estimated cost of outpatient care. "PHS" refers to expenditures by Public Health Service for personnel assigned to the Bureau's referral centers. This figure is added to the Bureau's inpatient care amount to yield a total federal expenditure for inpatient care. Patient/days includes days spent in both referral center beds and outside hospital beds. Obligations for medical equipment excluded.

Step 2: Estimating amount of non-medical expenditures to allocate health care. The purpose here is to estimate what proportion of all the prisons' non-medical functions should be attributed to cost of providing hospital care to prisoners.

	Total Facility Expenditures	All Non-Medical	Total Prisoner/ Days	% Patient/ Days of all Prisoner/Days
Lexington	\$20,033,090	\$13,490,067	475,419	5.15%
Butner	11,425,519	9,041,634	277,327	20.46%
Springfield	28,561,263	15,494,499	369,392	69.80%
Rochester	17,761,285	10,129,574	229,255	19.25%



	Non-Medical Costs Allocated to Health Care	Number of Patient Days	Estimated Daily Expenditures for All Non-Medical Functions Allo- cated to Health Care Per Patient
Lexington	\$694,821	24,487	\$28.38
Butner	1,850,176	56,749	32.60
Springfield	10,814,505	257,820	41.95
Rochester	1,949,829	44,129	44.18

NOTE: Non-Medical computed by subtracting all Decision Unit B and PHS costs from total facility expenditures. These costs are allocated to health care in the same proportion as patient days during FY 1988 were to total prisoner/days in each of the facilities. For example, 5.15 percent of all Lexington's prisoner/days during that year were patient/days, and that percentage of "all non-medical costs" were allocated to health care. This, in effect, represents that portion of overall facility support (security, food, maintenance, administration, etc.) that we estimate to be allocated to support in-patients in the prison hospitals.

Step 3: Combining all medical and allocated "all other" expenditures.

	Average Cost Per Patient
Lexington	\$247.70
Butner	\$64.50
Springfield	\$91.50
Rochester	\$206.22

SOURCES: Computed from miscellaneous data provided by the Bureau of Prisons. PHS costs were computed from data provided by Rhonda Ward, PHS/Bureau of Prisons.

Table B.2

## Estimating Cost of Outpatient Services at Referral Centers, FY 1988

1. BOP-wide total medical obligations (excluding equipment) (Defined as decision unit B)	\$82,080,291
2. Subtract medical obligations for Big Four referral centers (equipment excluded)	-26,549,940
3. Subtract expenditures for outside prison consultation and hospitalization (B25)	-17,339,308
4. Sum: obligations for medical services and operations outside of Big Four	\$38,191,043
5. Total number of prisoner/days in BOP system, not counting Big Four referral centers	14,692,395
6. Estimated cost per prisoner/day (line 4 divided by line 5)	\$2.60/day

NOTE: To compute the estimated cost of outpatient care in each of the Big Four referral centers, \$2.60/day is multiplied by the number of general population inmates, average daily census in FY 1988.

SOURCES: Obligations from Bureau of Prisons, miscellaneous accounting runs, provided by Dennis Callahan; man\day information from data provided by Jim Jones, Bureau of Prisons.

Table B.3

Average Expenditure for Consultants Services Inside  
Prisons and for Treatment of Prisoners Outside Facilities,  
Per Patient/Day, by Referral Center, FY 1988

Step 1: Estimating average per diem/patient expenditures for consultant services inside prisons to deliver services

	Total Cost of Consultant Services	Total Patient Days Outside & Inside	Average Per Patient/Day
Lexington	\$2,607,983	24,487	\$106.50
Butner	674,245	56,749	11.88
Springfield	2,691,435	257,820	10.43
Rochester	2,275,611	44,135	51.56

SOURCES: Expenditures for consultant services from Bureau of Prisons, identified as Decision Unit B50/250CN. Total patient days from BPMED3 reports.

Step 2: Estimating average per diem/patient expenditures for consultant services delivered to inpatients and outpatients outside prisons.

	Total Cost of Outside Services	Total Patient Days Outside & Inside	Average Per Patient/Day
Lexington	\$2,212,873	24,487	\$90.37
Butner	229,230	56,749	4.04
Springfield	1,781,682	257,820	6.91
Rochester	6,449	44,129	0.15

SOURCES: Expenditures for Decision Unit B25, Bureau of Prisons reports of obligations; patient days from BPMED# reports.

Table B.4

Estimating Component Costs of Inpatient Care,  
by Referral Center, FY 1988  
(Excluding Estimated Cost of Outpatient Care  
to General Population Inmates)

Step 1: Data

	Total Medical Labor	Total Security Costs (DU E)	Non-DUB allocated Health Care	All DUB	PHS
Butner	\$2,192,579	\$3,087,790	\$1,832,348	\$2,046,181	\$337,704
Lex.	\$5,392,845	\$3,973,352	\$700,452	\$6,008,881	\$534,142
Roch.	\$6,555,184	\$3,342,931	\$1,946,208	\$7,036,880	\$594,831
Spring.	\$10,794,845	\$6,761,790	\$10,736,546	\$12,281,602	\$785,161

Step 2: Allocating expenditures for outpatient care of general population.

	ratio "a"	op1	op2	Total Outpatient Cost
Butner	0.611688289	\$350,805	\$222,698	\$573,503
Lexington	0.766154562	\$898,257	\$274,166	\$1,172,423
Rochester	0.733701201	\$353,151	\$128,177	\$481,328
Springfield	0.565661412	\$164,091	\$125,996	\$290,087

NOTE: Ratio "a" = proportion of Total Medical Costs to the sum of: All DUB, PHS, non-DUB Allocated Health Care Costs, and minus Security Costs

OP1 = Outpatient Care costs allocated to medical labor

OP2 = Outpatient Care costs allocated to hospital expenditures

Step 3: Computing average per diem to expenditure of component costs of inpatient care.

	Medical Labor	Security	Hospital	Total Average Cost per Day
Butner	\$32.45	\$11.13	\$20.91	\$64.50
Lexington	\$183.55	\$8.36	\$55.79	\$247.70
Rochester	\$140.54	\$14.58	\$51.09	\$206.22
Springfield	\$41.23	\$18.31	\$31.96	\$91.50

NOTE: Medical per diem estimated by adding medical labor plus PHS, minus estimated share of outpatient costs allocated to medical, divided by total patient days.

Security per diem estimated by total DU E costs, multiplied by percentage of patient days to man days, divided by total patient days.

Hospital per diem estimated as residual of total estimated daily cost (see Table B.1), minus security per diem, minus medical per diem.

SOURCES: DUB and Medical Labor costs from Bureau of Prisons, Dennis Callahan; PHS expenditures from Rhonda Ward, PHS/Bureau of Prisons; Security costs from Jim Jones, Bureau of Prisons; non-DUB allocated Health Care estimated in Table B.1; Total outpatient costs estimated in Table B.2 (see note).

APPENDIX 2.—RESULTS OF A NATIONAL SURVEY BY B. JAYE ANNC  
PH.D., NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE,  
ENTITLED, "THE COST OF CORRECTIONAL HEALTH CARE"

THE COST OF CORRECTIONAL HEALTH CARE

The cost of health services in the United States has escalated dramatically in recent years.

At a congressional hearing in December 1989, a health policy expert testified that:

...U.S. health care spending exceeds \$600 billion/year and is rising faster than the Consumer Price Index (CPI). The reasons include: increases in physician and other professional services; increased service intensity; new technologies; inflation; and population growth and aging.<sup>1</sup>

Similarly, one would expect that the cost of providing health care to the nation's prisoners would have escalated for all of the reasons cited above as well as the added factor of litigation, which has forced a number of state correctional systems to increase their health care spending. But how much have these costs increased? A partial answer can be found by comparing the results of a survey undertaken by NCCHC in 1990 with results from similar published surveys.

In the spring of 1990, the National Commission on Correctional Health Care undertook a survey of the 50 state correctional systems and the Federal Bureau of Prisons (FBP) to determine how much each was spending on health services for prisoners. Usable responses were obtained from 46 states<sup>2</sup> and the FBP.

NCCHC's cost survey included questions regarding the fiscal period reported on, the total expenditure for the DOC during that period, the total expenditure for health service operations excluding new construction costs, a list of the program areas included in the health service cost totals, and the average daily number of inmates in the system for the year in question.

Every attempt was made to ensure that the data reported were comparable across the systems. Responses to the mail-out questionnaire were supplemented with telephone inquiries whenever questions arose as to the inclusion or exclusion of specific cost items. In all instances,

the figures reported include mental health services as well as medical and dental care. Where mental health services were provided by a different section of the DOC or by an outside agency with a separate budget, adjustments were made to the appropriate cost figure (e.g., the total health expenditure or both the total health expenditure and the total DOC expenditure). Similarly, adjustments were made for non-agency hospitalization costs if these were not included in the totals reported.

In spite of these efforts, care should be taken in the interpretation of the cost survey results. Without conducting a detailed comparison of the line items included in both the DOCs' total expenditure figures and their total health services expenditure figures, it is impossible to determine the extent to which the cost data are comparable. For example, it is not known what the jurisdictions may have included in their total DOC expenditure figure. It is assumed that this figure represents all costs for the DOC for the period reported, but if new construction costs were included in some states but not others, or if the extent of new construction differed dramatically among the states, that could account for at least a portion of the difference in the amount expended per inmate on an annual basis.

The total expended for health services should be a better figure, because here at least, the informants were asked specifically to exclude new construction costs and to include mental health costs even if the latter service was provided by a different section of the DOC or an outside agency. Further, an attempt was made to identify the types of costs included in the health figures reported. As shown in Table XIII-2, health care staffing was included in all of the figures reported and other "big ticket" items such as hospitalization, specialty care, equipment and pharmaceuticals were included in virtually all instances. The only areas of substantive variability were in the renovation/repair and overhead columns, neither of which is likely to be responsible for much distortion in the averages. However, no attempt was made to control for differences in the cost

of living among the states, so some of the variation in health care expenditures may be attributable simply to differences in the cost of care.

The time frame for which cost data were reported also differed to some extent (see Table A-1 in the appendix). While most of the states<sup>3</sup> (N=34) reported cost data for the same fiscal period of 7/1/88-6/30/89, Texas reported for FY 9/1/88-8/31/89, three states reported for the fiscal period 10/1/88-9/30/89, New York for FY 4/1/89-3/31/90, and eight states reported for their current fiscal year of 7/1/89-6/30/90. Thus, the time frame varied by as much as a year.

While the data within states are less problematic since the base and the time period are the same, the data among states are subject to all the *caveats* noted above. With this in mind, the survey results are presented below. Table XIII-1 summarizes the results alphabetically by state whereas tables presenting the results on specific variables in rank order (highest to lowest) by state can be found in the appendix.

Total DOC expenditures for the 47 jurisdictions reporting ranged from a low of \$12 million in Maine to a high of almost \$1.6 billion in California with the mean DOC expenditure totaling almost \$258 million. The median expenditure for the 47 jurisdictions was \$158 million (see Table A-2 in the appendix). Said another way, California's DOC was spending an average of about \$21,000 per inmate per year whereas Maine was spending only about half that much (\$10,041).

The total expenditures for health care ranged from a low of just over one million in South Dakota to almost \$150 million in California with a mean total expenditure of about \$25 million per state (see Table XIII-1) and a median of a little over \$10 million (see Table A-3 in the appendix).

The percent of the total DOCs' expenditures devoted to health ranged from a low of 2.8% in South Dakota to a high of 18.9% in Texas. The mean percentage expended on health was 9.5% (see Table XIII-1) whereas the median was 8% (see Table A-4 in the appendix).





TABLE XIII-2  
COMPARISON OF LINE ITEMS INCLUDED IN  
1989 HEALTH SERVICES COST DATA BY STATE

HEALTH SERVICE COST DATA INCLUDES:

STATE	HEALTH CARE STAFFING	SPECIALTY CARE	HOSPITAL CARE	PHARMACEUTICALS				EMERGENCY TRANSPORT	RENOVATION /REPAIR	OVERHEAD ITEMS	COMMENTS
				EQUIPMENT	SUPPLIES	TICALS					
AL	X	X	X	X*	X	X	X	X	X	X	*EXCEPT NEW FAC. EQUIP. *EXCEPT MAJOR RENOVATIONS
AK	X	X	X	X	X	X	X	X	X*	X	*REPAIR ONLY
AZ	X	X	X	X	X	X	X	X	X*	X	
AR	X	X	X	X	X	X	X	X	X	X	
CA	X	X	X	X	X	X	X	X	X	X	
CO	X	X	X	X	X	X	X	X	X	X	
CT	X	X	X	X	X	X	X	X	X	X	
DE	X	X	X	X	X	X	X	X	X	X	
FL	X	X	X	X	X	X	X	X	X	X	
GA	X	X	X	X	X	X	X	X	X	X	
ID	X	X	X	X	X	X	X	X	X	X	
IL	X	X	X	X	X	X	X	X	X	X	
IA	X	X	X	X	X	X	X	X	X	X	
KS	X	X	X	X	X	X	X	X	X	X	
KY	X	X	X	X	X	X	X	X	X	X	
LA	X	X	X	X	X	X	X	X	X	X	
ME	X	X	X	X	X	X	X	X	X	X	
MO	X	X	X	X	X	X	X	X	X	X	
MA	X	X	X	X	X	X	X	X	X	X	
MI	X	X	X	X	X	X	X	X	X	X	
MN	X	X	X	X	X	X	X	X	X	X	
MO	X	X	X	X	X	X	X	X	X	X	
MT	X	X	X	X	X	X	X	X	X	X	
NE	X	X	X	X	X	X	X	X	X	X	
NV	X	X	X	X	X	X	X	X	X	X	
NH	X	X	X	X	X	X	X	X	X	X	
NJ	X	X	X	X	X	X	X	X	X	X	
NM	X	X	X	X	X	X	X	X	X	X	
NY	X	X	X	X	X	X	X	X	X	X	
NC	X	X	X	X	X	X	X	X	X	X	
ND	X	X	X	X	X	X	X	X	X	X	
OK	X	X	X	X	X	X	X	X	X**	X	*LOCAL & EMERG. ONLY, **EQUIP. ONLY
OR	X	X	X	X	X	X	X	X	X	X	
PA	X	X	X	X	X	X	X	X	X	X	
RI	X	X	X	X	X	X	X	X	X	X	
SC	X	X	X	X	X	X	X	X	X	X	
SD	X	X	X	X	X	X	X	X	X	X	
TN	X	X	X	X	X	X	X	X	X	X	
TX	X	X	X	X	X	X	X	X	X*	X	*EXCEPT MAJOR RENOVATION
UT	X	X	X	X	X	X	X	PARTIAL	X	X	
VT	X	X	X	X	X	X	X	X	X	X	
VA	X	X	X	X	X	X	X	X	X	X	
WA	X	X	X	X	X	X	X	X	X	X	
WV	X	X	X	X	X	X	X	X	X	X	
WI	X	X	X	X	X	X	X	X	X	X	
WY	X	X	X	X	X	X	X	X	X	X	
WY	X*	X	X	X	X	X	X	X	X	X	
WY	X*	X	X	X	X	X	X	X	X	X	
TOTALS	47	46	46	45	46	46	42	27	20	20	

\*INCLUDES PSYCHIATRIC, BUT NOT PSYCHOLOGICAL SERVICES

The annual health cost per inmate varied significantly. South Dakota spent an average of only \$787 per inmate per year on health services whereas Alaska spent over four times that much (\$3381) annually per inmate on its health services (see Table XIII-1). The average expenditure per inmate per year across the 47 jurisdictions reporting was \$1906 while the median expenditure was \$1665 (see Table A-5 in the appendix).

In presenting these gross cost data, it is recognized that there is a danger that the results will be misinterpreted. To conclude that Alaska's DOC had the "best" correctional health care system in 1989 and South Dakota's the "worst," based on the amount expended, would be in error. The potential disparities in the way these data were collected as well as the lack of control for intervening variables such as differences in the cost of living (and cost of health care) among the states render such an interpretation specious.

Additionally, more is not always better. It may be that some of the systems that spend less are actually more efficient in monitoring and controlling their health care costs. A much more detailed cost study is needed before any reliable conclusions can be drawn about the relationship between quality of care and cost.

The primary value of these data lies in comparing the cost expended on health services annually within the same state over time. There are only two published studies known that can be used for comparative purposes. Contact, Inc. conducted cost surveys in 1983 and again in 1986 that covered essentially the same variables as NCCHC's 1990 survey. The reported data from both Contact, Inc. surveys were reformatted to conform to NCCHC's data for comparative purposes. While all of the limitations of the Contact, Inc. cost surveys are not known, based on the information provided, it is reasonable to assume that the same *caveats* apply as those discussed in conjunction with NCCHC's cost survey.

Table A-6 in the appendix summarizes Contact, Inc.'s 1983 survey and Table A-7 its 1986 survey. In 1982, the 36 DOC jurisdictions reporting were spending an average of 7.2% of their total expenditures on health services at an average annual cost of \$883 per inmate (see Table A-6). By 1985, the 46 DOC jurisdictions reporting were spending an average of only 6.8% on health services, but at an average annual cost of \$1230 per inmate (see Table A-7 in the appendix). By 1989, these figures had climbed to an average of 9.5% and \$1906 per inmate per year respectively for the 47 jurisdictions reporting (see Table XIII-1).

In order to make these comparisons more accurately, Table XIII-3 shows the changes in annual health cost per inmate from 1982-1989 and then 1985-1989, using data only from those states that reported in both years. From this chart, it can be seen that the average annual expenditure per inmate for health care increased from \$893 in 1982 to \$1814 in 1989, which represents a difference of \$921 or an average growth of 103.1% over the seven year period. For the four year period of 1985-1989, average annual health expenditures per inmate increased from \$1235 to \$1906 or 54.3% (\$671). In both instances, the rate of increase was well above the annual inflation rate and hence, undoubtedly represents real expansion in the extent of staff, services etc.<sup>4</sup>

The best comparison of health care costs, though, is to look only at those jurisdictions that reported expenditures for all three time periods (see Table XIII-4). There were 31 such states. Of these, four decreased the amount spent annually per inmate for health services between 1982 and 1989. Alabama showed the most substantial decrease between 1982 and 1989 (almost 25% less expended per inmate for health care in 1989). This decrease seems to have occurred in more recent years, since a comparison of Alabama's 1982 to 1985 figures shows an increasing trend. While all of the factors accounting for this decrease are not known, the Alabama DOC did put its health services out for re-bid in 1988 and selected a new contractor at a lower price. The other

TABLE XIII-3  
COMPARISON OF CHANGES IN PER INMATE  
ANNUAL INMATE COST BY STATE BY YEAR  
(1982-1989 AND 1985-1989)

STATE	1982-1989			1985-1989		
	1989	1982	CHANGE	1989	1985	CHANGE
AL	\$792	\$1,053	(\$261)	\$792	\$1,230	(\$447)
AK	\$3,381	\$1,202	\$2,179	\$3,381	\$2,423	\$958
AZ	\$1,913	\$2,141	(\$228)	\$1,913	\$2,269	\$356
AR	\$1,395	\$1,190	\$205	\$1,395	\$1,072	\$323
CA	\$1,923	\$1,717	\$206	\$1,923	\$1,895	\$28
CO	\$1,154	\$1,249	(\$95)	\$1,154	\$1,317	(\$163)
CT	\$2,108	\$591	\$1,517	\$2,108	\$757	\$1,351
DE	\$1,524	\$857	\$667	\$1,524	\$1,150	\$374
GA	\$1,648	\$919	\$729	\$1,648	\$1,104	\$544
HI	\$1,560	\$984	\$576	\$1,560	\$1,259	\$301
IL	\$1,640	\$706	\$934	\$1,560	\$1,150	\$410
IN	\$831	\$588	\$243	\$1,518	\$1,113	\$405
LA	\$1,870	\$1,095	\$775	\$1,518	\$576	\$942
ME	\$1,226	\$683	\$543	\$1,210	\$576	\$634
MD	\$2,157	\$947	\$1,210	\$1,210	\$576	\$634
MI	\$1,870	\$1,095	\$775	\$1,210	\$576	\$634
MN	\$1,648	\$710	\$938	\$1,210	\$576	\$634
NE	\$1,648	\$710	\$938	\$1,210	\$576	\$634
NH	\$1,648	\$710	\$938	\$1,210	\$576	\$634
NJ	\$1,648	\$710	\$938	\$1,210	\$576	\$634
NM	\$1,648	\$710	\$938	\$1,210	\$576	\$634
NY	\$1,648	\$710	\$938	\$1,210	\$576	\$634
NC	\$1,648	\$710	\$938	\$1,210	\$576	\$634
ND	\$1,648	\$710	\$938	\$1,210	\$576	\$634
OR	\$1,648	\$710	\$938	\$1,210	\$576	\$634
PA	\$1,648	\$710	\$938	\$1,210	\$576	\$634
RI	\$1,648	\$710	\$938	\$1,210	\$576	\$634
SC	\$1,648	\$710	\$938	\$1,210	\$576	\$634
SD	\$1,648	\$710	\$938	\$1,210	\$576	\$634
TN	\$1,648	\$710	\$938	\$1,210	\$576	\$634
TX	\$1,648	\$710	\$938	\$1,210	\$576	\$634
VA	\$1,648	\$710	\$938	\$1,210	\$576	\$634
VT	\$1,648	\$710	\$938	\$1,210	\$576	\$634
WV	\$1,648	\$710	\$938	\$1,210	\$576	\$634
WI	\$1,648	\$710	\$938	\$1,210	\$576	\$634
WY	\$1,648	\$710	\$938	\$1,210	\$576	\$634
FEP	\$2,392	\$1,214	\$1,178	\$2,392	\$1,456	\$936
N=33	\$1,816*	\$893**	\$921	\$1,906*	\$1,235**	\$671

\*ADJUSTED WEIGHTED AVERAGE WITH 5 STATES DELETED  
(I.E., THOSE WITHOUT 1985 DATA)  
\*\*ADJUSTED WEIGHTED AVERAGE WITH 4 STATES DELETED  
(I.E., THOSE WITHOUT 1989 DATA)

\*ADJUSTED WEIGHTED AVERAGE WITH 14 STATES DELETED  
(I.E., THOSE WITHOUT 1982 DATA)  
\*\*ADJUSTED WEIGHTED AVERAGE WITH 3 STATES DELETED  
(I.E., THOSE WITHOUT 1989 DATA)

TABLE XIII-4  
COMPARISON OF CHANGES IN PER INMATE  
ANNUAL HEALTH COST BY STATE FOR THREE TIME PERIODS  
(1982, 1985 and 1989)

STATE	\$ 1989	\$ 1985	\$ CHANGE (85-89)	% CHANGE (85-89)	\$ 1982	\$ CHANGE (82-89)	% CHANGE (82-89)
AL	\$792	\$1,239	(\$447)	-36.1%	\$1,053	(\$261)	-24.8%
AK	\$3,381	\$2,423	\$958	39.5%	\$1,202	\$2,179	181.3%
AZ	\$1,913	\$1,269	\$644	50.7%	\$2,141	(\$228)	-10.6%
AR	\$1,595	\$1,072	\$523	48.8%	\$968	\$627	64.8%
CA	\$1,953	\$1,893	\$60	3.2%	\$1,171	\$782	66.8%
CO	\$1,154	\$1,317	(\$163)	-12.4%	\$1,249	(\$95)	-7.6%
CT	\$2,108	\$757	\$1,351	178.5%	\$591	\$1,517	256.7%
DE	\$1,524	\$1,150	\$374	32.5%	\$857	\$667	77.8%
GA	\$1,648	\$1,259	\$389	30.9%	\$919	\$729	79.3%
ID	\$1,560	\$1,150	\$410	35.7%	\$984	\$576	58.5%
LA	\$831	\$801	\$30	3.7%	\$588	\$243	41.3%
ME	\$1,870	\$1,161	\$709	61.1%	\$1,095	\$775	70.8%
MD	\$1,226	\$1,019	\$207	20.3%	\$683	\$543	79.5%
MN	\$2,157	\$2,039	\$118	5.8%	\$947	\$1,210	127.8%
MT	\$1,665	\$772	\$893	115.7%	\$710	\$955	134.5%
NE	\$1,795	\$1,300	\$495	38.1%	\$1,216	\$579	47.6%
NH	\$1,941	\$1,448	\$493	34.0%	\$1,648	\$293	17.8%
NM	\$2,900	\$2,600	\$300	11.5%	\$1,247	\$1,653	132.6%
NC	\$1,973	\$1,398	\$575	41.1%	\$886	\$1,087	122.7%
OK	\$909	\$968	(\$59)	-6.1%	\$935	(\$26)	-2.8%
OR	\$1,868	\$1,173	\$695	59.2%	\$1,017	\$851	83.7%
PA	\$1,429	\$1,184	\$245	20.7%	\$836	\$593	70.9%
RI	\$1,711	\$1,762	(\$51)	-2.9%	\$1,682	\$29	1.7%
SC	\$1,387	\$717	\$670	93.4%	\$593	\$794	133.9%
SD	\$787	\$1,039	(\$252)	-24.3%	\$532	\$255	47.9%
TN	\$1,962	\$1,300	\$662	50.9%	\$737	\$1,225	166.2%
TX	\$2,262	\$1,700	\$562	33.1%	\$395	\$1,867	472.7%
WA	\$2,664	\$461	\$2,203	477.9%	\$845	\$1,819	215.3%
WI	\$1,695	\$1,019	\$676	66.3%	\$919	\$776	84.4%
WY	\$1,264	\$800	\$464	58.0%	\$479	\$785	163.9%
FBP	\$2,392	\$1,456	\$936	64.3%	\$1,214	\$1,178	97.0%
N=31	\$1,848*	\$1,394**	\$454	32.6%	\$906***	\$942	104.0%

\*ADJUSTED WEIGHTED AVERAGE WITH 16 STATES DELETED (i.e., THOSE WITHOUT EITHER 1985 OR 1982 DATA).

\*\*ADJUSTED WEIGHTED AVERAGE WITH 15 STATES DELETED (i.e., THOSE WITHOUT EITHER 1989 OR 1982 DATA).

\*\*\*ADJUSTED WEIGHTED AVERAGE WITH 5 STATES DELETED (i.e., THOSE WITHOUT EITHER 1989 OR 1985 DATA).

three states whose annual health expenditure per inmate declined over time are Arizona (-10.6%), Colorado (-7.6%) and Oklahoma (-2.8%).

In the remaining 27 states, the per inmate annual health cost increased over time and in virtually all cases, at a rate well above the rate of inflation. In fact, in eleven of these cases, the increase was over 100%. Texas had the most dramatic increase in its annual health expenditure per inmate -- a whopping 472.7% rise in the seven year period from 1982 to 1989. This state has had one of the longest running class action suits (the *Ruiz* case) involving unconstitutional conditions of confinement including health care. It is interesting to note that the time period of 1982-1989 corresponds with the dates of the appointment by the federal court of a special master and a monitor for health services.<sup>5</sup> Unquestionably, much of the increase in Texas' health expenditure is attributable to real expansion in the extent and type of services offered.<sup>6</sup>

On an average basis, these 31 states increased their per inmate annual health expenditure 104% in seven years. They spent \$906 per inmate for health care in 1982, \$1394 in 1985 and \$1848 in 1989. For most of the states, it is fair to assume that the increase in expenditures reflects some increase in services, but the question is "How much?" Unfortunately, this question cannot be answered by the present study. It is hoped that future studies will examine correctional health care spending in greater detail and control for intervening variables such as the cost of living in different states and the rate of inflation. Additionally, it would be useful to have cost data broken down by program area (e.g., medical, dental and mental health care); by service (e.g., hospitalization, specialty care, laboratory, radiology); and by inmate age and illness categories.

## ENDNOTES

1. Kenneth Thorpe as cited in "Select Committee...(1989).
2. Health cost data could not be obtained from the correctional systems in Hawaii, Indiana, Mississippi and North Dakota.
3. Technically, the Federal Bureau of Prisons is not a state; however, to avoid repetition, the terms "state" and "jurisdiction" are used interchangeably and "state" is intended to include the FBP where appropriate.
4. According to Kuemmerling and Howell (1990), the Consumer Price Index (CPI) for both 1982 and 1985 was 3.8%, whereas for 1989, the CPI was 4.6%.
5. Mr. Vincent Nathan and Ms. Jacqueline Boney respectively.
6. In the same seven year period, the Texas DOC's health delivery system went from one of the worst to one of the best. It has the distinction of being the only state prison system to have the health delivery systems in all of its prison units accredited by NCCHC.

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**APPENDIX**

TABLE A-1  
COMPARISON OF FISCAL YEAR  
BY STATE

STATE	FISCAL YEAR
AK	7/1/88-6/30/89B
AZ	7/1/88-6/30/89B
CA	7/1/88-6/30/89B
CO	7/1/88-6/30/89B
DE	7/1/88-6/30/89B
FL	7/1/88-6/30/89B
GA	7/1/88-6/30/89B
ID	7/1/89-6/30/90C
IL	7/1/88-6/30/89B
IA	7/1/88-6/30/89B
KS	7/1/88-6/30/89B
KY	7/1/88-6/30/89B
LA	7/1/88-6/30/89B
ME	7/1/88-6/30/89B
MD	7/1/88-6/30/89B
MN	7/1/88-6/30/89B
MO	7/1/88-6/30/89B
MT	7/1/88-6/30/89B
NE	7/1/88-6/30/89B
NV	7/1/88-6/30/89B
NH	7/1/88-6/30/89B
NJ	7/1/88-6/30/89B
NC	7/1/88-6/30/89B
OH	7/1/88-6/30/89B
OK	7/1/88-6/30/89B
OR	7/1/89-6/30/90C
PA	7/1/88-6/30/89B
RI	7/1/88-6/30/89B
SC	7/1/88-6/30/89B
SD	7/1/88-6/30/89B
TN	7/1/88-6/30/89B
UT	7/1/88-6/30/89B
VA	7/1/88-6/30/89B
WV	7/1/88-6/30/89B
WI	7/1/88-6/30/89B
WY	7/1/88-6/30/89B
TX	9/1/88-8/31/89E
AL	10/1/88-9/30/89A
MI	10/1/88-9/30/89A
FBP	10/1/88-9/30/89A
NY	4/1/89-3/31/90D
AR	7/1/89-6/30/90C
CT	7/1/89-6/30/90C
MA	7/1/89-6/30/90C
NM	7/1/89-6/30/90C
VT	7/1/89-6/30/90C
WA	7/1/89-6/30/90C
=====	
N=47	

KEY

A = 10/1/88-9/30/89  
 B = 7/1/88-6/30/89  
 C = 7/1/89-6/30/90  
 D = 4/1/89-3/31/90  
 E = 9/1/88-8/31/89

TABLE A-2  
COMPARISON OF 1989 TOTAL DOC  
EXPENDITURES IN RANK ORDER BY STATE

STATE*	TOTAL DOC EXPENDITURE	TOTAL HEALTH EXPENDITURE INCLUDING MENTAL HEALTH	% OF TOTAL DOC EXPENDITURE DEDICATED TO HEALTH	ANNUAL HEALTH COST PER INHABITANT	FISCAL YEAR**	COMMENTS
CA	\$1,593,256,000	\$149,660,000	9.4%	\$1,953	1988-89	
NY	\$1,094,159,100*	\$111,799,700*	10.2%	\$2,249	1989-90	*INCLUDES \$30 MIL. FROM MENTAL HEALTH AGENCY
MP	\$960,490,600	\$114,345,162	11.9%	\$2,392	1988-89	
FL	\$694,287,968	\$95,766,619	13.8%	\$2,706	1988-89	*INCLUDES MENTAL HEALTH SECURITY COSTS
MI	\$689,449,480*	\$75,000,687*	10.9%	\$2,636	1988-89	
OH	\$688,400,000	\$39,600,000	5.8%	\$1,366	1988-89	
TX	\$608,000,136*	\$95,838,477*	15.9%	\$2,262	1988-89	*INCLUDES 16.25 MIL. FOR OUTSIDE AGENCY HOSPITALIZATION
IL	\$437,700,000	\$34,100,000	7.8%	\$1,370	1988-89	
MA	\$437,175,000	\$17,000,000	3.9%	\$2,310	1988-89	
WJ	\$364,733,767	\$19,500,000	5.1%	\$1,500	1988-89	
VA	\$320,743,218	\$27,404,365	8.5%	\$1,648	1988-89	
GA	\$319,888,293	\$34,747,165	10.9%	\$1,973	1988-89	
NC	\$269,913,000	\$25,235,000	9.3%	\$1,429	1988-89	
PA	\$265,514,787	\$16,713,211	6.3%	\$1,226	1988-89	
MO	\$229,628,000	\$14,427,500	6.3%	\$1,962	1988-89	
TN	\$226,450,000*	\$21,175,000*	9.4%	\$2,379	1988-89	*ADJUSTED FOR SPECIAL HOSPITALIZATION COSTS
AZ	\$221,675,400	\$24,551,201	11.1%	\$1,913	1988-89	
WA	\$213,542,450	\$18,648,640	8.7%	\$2,664	1988-89	
KS	\$189,000,000	\$16,000,000	8.5%	\$1,600	1988-89	
CO	\$185,342,712	\$10,395,142	5.1%	\$2,181	1988-89	
CT	\$195,896,302	\$18,643,354	9.5%	\$2,108	1988-89	
SC	\$183,732,201	\$19,479,068	10.6%	\$1,387	1988-89	
MO	\$166,050,089	\$11,409,617	6.9%	\$907	1988-89	*INCLUDES \$2.9 MIL. FOR MENTAL HEALTH SERVICES
WI	\$158,201,700*	\$10,800,000*	6.8%	\$1,695	1988-89	
OK	\$142,289,266	\$9,093,988	6.4%	\$909	1988-89	
AL	\$134,808,444	\$9,493,748	7.0%	\$1,868	1988-89	*INCLUDES \$1.85 MIL. FROM OUTSIDE MENTAL HEALTH AGENCY
OR	\$117,000,000	\$7,500,000	6.4%	\$1,110	1988-89	
KY	\$109,337,000	\$10,400,000	9.5%	\$1,510	1988-89	
IN	\$109,200,000	\$10,400,000	9.5%	\$1,510	1988-89	
MD	\$94,303,300	\$8,643,000	9.1%	\$3,381	1988-89	
NH	\$92,303,300	\$8,234,800	8.9%	\$2,900	1988-89	
DE	\$74,326,000	\$4,781,100	6.4%	\$1,524	1988-89	
UT	\$61,677,566	\$2,331,752	3.8%	\$1,174	1988-89	*INCLUDES \$1,226,987 IN NON-DOC DOLLARS
IA	\$60,845,599*	\$4,982,875*	8.2%	\$1,618	1988-89	
AR	\$55,782,785	\$9,495,347	17.0%	\$1,595	1988-89	
KV	\$52,690,523	\$8,621,933	16.4%	\$1,764	1988-89	
RI	\$46,130,805*	\$3,395,953*	7.4%	\$1,987	1988-89	*ADULT POPULATION ONLY
ME	\$45,054,000	\$2,400,000	5.3%	\$1,795	1988-89	
SE	\$36,123,357	\$1,013,393	2.8%	\$787	1988-89	
ND	\$29,797,400	\$2,847,504	9.6%	\$1,560	1988-89	
VT	\$26,000,000	\$1,387,000	5.3%	\$1,558	1988-89	
MT	\$22,287,160	\$1,717,927	7.7%	\$1,665	1988-89	
NH	\$22,237,822	\$1,746,660	7.9%	\$1,941	1988-89	
WV	\$21,308,964*	\$1,603,512*	7.5%	\$1,035	1988-89	*ADULT POPULATION ONLY
WY	\$13,961,191	\$1,122,205	8.0%	\$1,264	1988-89	
NE	\$11,999,372	\$2,433,133	20.3%	\$1,500	1988-89	
WY	\$11,778,000	\$2,433,133	20.6%	\$1,500	1988-89	

\*NO DATA FOR MT, HI, MS, AND ND;

\*\*KEY: A = 10/1/88-9/30/89, B = 7/1/88-6/30/89, C = 7/1/89-6/30/90, D = 4/1/89-3/31/90, E = 9/1/88-8/31/89.

< > = MEDIAN

TABLE A-3  
COMPARISON OF 1989 TOTAL CORRECTIONAL HEALTH EXPENDITURES  
IN RANK ORDER BY STATE

STATE	TOTAL DOC EXPENDITURE	TOTAL HEALTH EXPENDITURE INCLUDING MENTAL HEALTH	% OF TOTAL DOC EXPENDITURE DEVOTED TO HEALTH	ANNUAL HEALTH COST PER INMATE	TOTAL INMATE POPULATION (ADP)	FISCAL YEAR**	COMMENTS
CA	\$1,593,256,000	\$149,660,000	9.4%	\$1,953	76,633	1988-89	
FBP	\$960,490,600	\$114,345,162	11.9%	\$2,392	47,804	1988-89A	
NY	\$1,094,159,100*	\$111,799,700*	10.2%	\$2,249	49,711	1989-90D	*INCLUDES \$30 MIL. FROM MENTAL HEALTH AGENCY
TX	\$508,000,136*	\$95,838,477*	18.9%	\$2,262	42,365	1988-89E	*INCLUDES \$16.25 MIL. FOR OUTSIDE AGENCY HOSPITALIZATION
FL	\$694,287,968	\$95,766,619	13.8%	\$2,706	35,386	1988-89F	
MI	\$689,449,480*	\$75,000,680*	10.9%	\$2,636	28,451	1988-89G	*INCLUDES MENTAL HEALTH SECURITY COSTS
OH	\$688,400,000	\$37,600,000	5.5%	\$1,366	27,531	1988-89H	
NJ	\$371,874,000	\$27,665,000	7.4%	\$2,016	13,646	1988-89I	
IL	\$437,700,000	\$24,767,160	5.7%	\$1,973	12,516	1988-89J	
GA	\$320,763,218	\$27,404,345	8.5%	\$1,570	17,610	1988-89K	
PA	\$269,913,000	\$25,235,000	9.3%	\$1,648	16,631	1988-89L	
AZ	\$221,675,400	\$24,551,201	11.1%	\$1,913	12,836	1988-89M	
MA	\$226,450,000*	\$21,175,000*	9.4%	\$2,379	8,900	1989-90C	*ADJUSTED FOR SPECIAL HOSPITALIZATION COSTS
VA	\$384,733,767	\$19,500,000	5.1%	\$1,500	13,000	1988-89N	
SC	\$183,732,201	\$19,479,068	10.6%	\$1,387	14,049	1988-89O	
WA	\$213,542,450	\$18,648,840	8.7%	\$2,664	7,000	1989-90C	
CT	\$255,514,787	\$16,713,211	6.5%	\$2,108	7,845	1988-89P	
MO	\$195,896,302	\$16,643,344	8.5%	\$2,182	7,630	1988-89Q	
ND	\$168,850,000	\$14,765,000	8.7%	\$1,582	9,325	1988-89R	
WY	\$164,050,089	\$11,469,617	6.9%	\$1,962	7,354	1988-89S	
UT	\$158,201,700*	\$10,800,000*	6.8%	\$1,695	12,573	1988-89T	*INCLUDES \$2.9 MIL. FOR MENTAL HEALTH SERVICE
LA	\$205,342,717	\$10,395,142	5.1%	\$431	12,505	1988-89U	
OR	\$128,689,876*	\$10,245,482**	8.0%	\$1,868	5,484	1989-90C	*INCLUDES \$1.85 MIL. FROM OUTSIDE MENTAL HEALTH AGENCY
KS	\$210,000,000	\$9,916,000	4.7%	\$1,640	6,048	1988-89V	
AR	\$55,782,785	\$9,495,347	17.0%	\$1,595	5,954	1989-90C	
AL	\$134,888,444	\$9,493,748	7.0%	\$792	11,990	1988-89A	
OK	\$142,289,266	\$9,095,968	6.4%	\$909	10,000	1988-89B	
AK	\$94,500,000	\$8,643,000	9.1%	\$3,381	2,536	1988-89C	
WV	\$52,696,523	\$8,621,933	16.4%	\$2,819	3,068	1988-89D	
HI	\$32,303,300	\$8,566,600	26.5%	\$2,906	2,840	1989-90C	
CT	\$187,000,000	\$7,500,000	4.0%	\$1,210	6,200	1988-89E	
CO	\$99,203,000	\$7,277,599	7.3%	\$1,154	6,306	1988-89F	
ND	\$115,339,305	\$6,254,849	5.4%	\$2,157	2,900	1988-89G	
DE	\$40,845,599*	\$4,982,876*	8.2%	\$1,618	3,079	1988-89H	*INCLUDES \$1,226,987 IN NON-DOC DOLLARS
IA	\$76,326,900	\$4,781,100	6.4%	\$1,524	3,138	1988-89I	
ME	\$44,504,585	\$4,212,439	9.5%	\$1,795	2,347	1988-89J	
RI	\$46,130,805*	\$3,599,933*	7.1%	\$1,711	1,987	1988-89K	*ADULT POPULATION ONLY
ID	\$29,797,400	\$2,847,504	9.6%	\$1,560	1,825	1989-90C	
UT	\$61,677,566	\$2,331,752	3.8%	\$1,174	1,986	1988-89L	
NE	\$11,999,372	\$2,235,135	18.6%	\$1,870	1,195	1988-89M	
NH	\$22,237,822	\$1,746,660	7.9%	\$1,741	1,000	1988-89N	
MT	\$22,287,664	\$1,617,748	7.3%	\$1,665	1,032	1988-89O	
WY	\$28,000,000	\$1,403,512*	5.0%	\$1,465	1,550	1988-89P	*ADULT POPULATION ONLY
VT	\$24,000,000	\$1,387,000	5.8%	\$1,558	890	1989-90C	
WV	\$15,961,191	\$1,222,205	8.0%	\$1,264	888	1988-89Q	
SD	\$36,123,327	\$1,013,393	2.8%	\$787	1,287	1988-89R	
ND	\$257,754,222	\$24,569,436	9.5%	\$1,906	12,890	1988-89S	

\*\*ADJ. AVERAGES: \$257,754,222 \$24,569,436  
\*DO DATA FOR RI, IL, MS, AND MO; \*\*KEY: A = 10/1/88-9/30/89, B = 7/1/88-6/30/89, C = 7/1/89-6/30/90, D = 4/1/89-3/31/90, E = 9/1/88-8/31/89.  
< = MEDIAN

TABLE A-4  
COMPARISON OF % OF 1989 TOTAL DDC EXPENDITURES  
DEVOTED TO HEALTH IN RANK ORDER BY STATE

STATE	TOTAL DDC EXPENDITURE \$100,000,000*	TOTAL HEALTH EXPENDITURE \$100,000,000*	% OF TOTAL DDC EXPENDITURE TO HEALTH	ANNUAL HEALTH COST PER INHABITANT	(ADP) TOTAL POPULATION	FISCAL YEAR*	COMMENTS
TX	\$100,000,136*	\$95,839,477*	18.9%	\$2,262	42,365	1988-89	*INCLUDES 16.25 MIL. FROM OUTSIDE AGENCY HOSPITALIZATION
NE	\$11,999,372	\$2,235,135	18.6%	\$1,870	1,195	1988-89	
ME	\$55,782,785	\$9,495,347	17.0%	\$1,595	5,954	1989-90C	
NV	\$52,696,523	\$8,621,933	16.4%	\$1,764	4,887	1988-89	
FL	\$694,287,968	\$95,766,619	13.8%	\$2,706	35,386	1988-89	
FBP	\$960,490,600	\$114,345,162	11.9%	\$2,392	47,804	1988-89A	
AZ	\$221,675,400	\$24,551,201	11.1%	\$1,913	12,836	1988-89	*INCLUDES MENTAL HEALTH SECURITY COSTS
MI	\$689,449,480*	\$75,000,687*	10.9%	\$2,636	29,451	1988-89	
NC	\$319,888,293	\$34,747,160	10.9%	\$1,795	18,755	1988-89	
WY	\$183,732,201	\$19,799,700*	10.8%	\$1,387	14,049	1988-89	
SC	\$1,329,787,400	\$111,799,700*	10.2%	\$2,269	49,711	1989-90C	*INCLUDES \$30 MIL. FROM MENTAL HEALTH AGENCY
CT	\$391,574,000	\$37,364,000	9.6%	\$1,560	1,825	1989-90C	
RI	\$195,896,302	\$18,643,344	9.5%	\$2,016	18,538	1988-89	
CA	\$44,504,585	\$4,212,439	9.5%	\$2,108	8,845	1989-90C	
NE	\$1,593,256,000	\$159,660,000	9.4%	\$1,795	2,347	1988-89	
MA	\$226,450,000*	\$21,175,000*	9.4%	\$1,953	76,633	1988-89	
PA	\$269,913,000	\$25,235,000	9.4%	\$2,379	8,900	1989-90C	
AK	\$94,500,000	\$8,643,000	9.3%	\$1,429	17,662	1988-89	
NH	\$92,303,300	\$8,256,800	9.1%	\$1,381	5,985	1988-89	
OR	\$183,684,500	\$18,643,000	8.7%	\$2,901	2,840	1989-90C	
GA	\$320,733,218	\$27,404,345	8.5%	\$2,664	7,000	1989-90C	
LA	\$60,465,599*	\$4,982,875*	8.2%	\$1,618	16,631	1988-89	*INCLUDES \$1,226,987 IN NON-DDC DOLLARS
WY	\$13,961,191	\$1,122,205	8.0%	\$1,264	888	1988-89	
OK	\$128,689,876*	\$10,245,482*	8.0%	\$1,868	5,484	1989-90C	*INCLUDES \$1.05 MIL. FROM OUTSIDE MENTAL HEALTH AGENCY
NH	\$22,237,822	\$1,746,660	7.9%	\$1,941	900	1988-89	
IL	\$437,700,000	\$34,100,000	7.8%	\$1,570	21,714	1988-89	
MT	\$22,287,160	\$1,717,927	7.7%	\$1,665	1,132	1988-89	*ADULT POPULATION ONLY
WY	\$21,308,964*	\$1,603,512*	7.5%	\$1,055	1,552	1988-89	
CO	\$99,203,000	\$7,277,999	7.3%	\$1,154	6,306	1988-89	*ADULT POPULATION ONLY
RI	\$142,382,822	\$9,431,927	7.1%	\$1,711	1,987	1988-89	
AL	\$138,484,444	\$9,431,927	7.0%	\$792	11,990	1988-89A	
WY	\$166,950,089	\$11,409,617	6.9%	\$907	12,573	1988-89	
MO	\$158,201,700*	\$10,800,000*	6.8%	\$1,695	6,373	1988-89	*INCLUDES \$2.9 MIL. FROM MENTAL HEALTH SERVICE
ND	\$245,514,787	\$16,713,211	6.8%	\$1,226	13,630	1988-89	
DE	\$74,326,900	\$4,781,100	6.4%	\$1,524	3,138	1988-89	
OK	\$117,000,000	\$7,500,000	6.4%	\$1,210	6,200	1988-89	
KY	\$142,289,266	\$9,093,988	6.4%	\$1,940	10,400	1988-89	
TX	\$259,628,000	\$16,427,500	6.3%	\$1,622	17,350	1988-89	
OH	\$168,400,000	\$10,600,000	6.3%	\$1,366	29,000	1988-89	
VT	\$13,339,305	\$4,254,049	5.4%	\$2,157	2,900	1988-89	
VA	\$384,733,767	\$19,500,000	5.1%	\$1,558	890	1989-90C	
LA	\$205,342,717	\$10,395,142	5.1%	\$831	13,000	1988-89	
ES	\$210,000,000	\$9,916,000	4.7%	\$1,640	12,505	1988-89	
UT	\$61,677,566	\$2,331,752	3.8%	\$1,174	6,048	1988-89	
SD	\$56,123,357	\$1,013,393	2.0%	\$1,397	1,986	1988-89	
MT	\$257,756,222	\$24,569,436	9.5%	\$1,870	12,800	1988-89	

N=47 AVERAGES: \$257,756,222 \$24,569,436 9.5% \$1,870 12,800  
\*NO DATA FOR HI, HI, HI, AND HI; \*RET: A = 10/1/88-9/30/89, B = 7/1/88-6/30/89, C = 7/1/89-6/30/90, D = 4/1/89-3/31/90, E = 9/1/88-8/31/89. < > = MEDIAN



TABLE A-6  
COMPARISON OF CORRECTIONAL HEALTH SERVICE  
COSTS BY STATE (1982)

STATE*	YEAR	TOTAL DOC EXPENDITURE	TOTAL HEALTH EXPENDITURE INCLUDING MENTAL HEALTH	% OF TOTAL DOC EXPENDITURE DEVOTED TO HEALTH	ANNUAL HEALTH COST PER INMATE	TOTAL INMATE POPULATION	NOTES
AL	FY 81-82	\$54,840,532	\$6,206,750	11.3%	\$1,053	5,892	1. This table was derived from data published by Contact, Inc., VIII Corrections Compendium 2: 5-11 (August, 1983).
AK	1982	\$32,483,584	\$1,448,239	4.5%	\$1,202	1,205	
AZ	FY 81-82	\$95,028,400	\$10,532,100	11.1%	\$2,141	4,919	
AR	1982	\$26,900,538	\$3,423,720	12.7%	\$968	3,736	
CA	FY 82-83	\$548,000,000	\$39,108,000	7.1%	\$1,111	32,500	2. Average based on the 33 areas with data.
CO	1982	\$47,000,000	\$3,622,729	7.7%	\$1,199	2,900	
CT	1982	\$35,000,000	\$3,000,000	N/A	\$591	5,075	3. Average based on all 36 jurisdictions reporting.
DE	1982	\$29,361,400	\$1,406,600	5.5%	\$857	1,875	
DC	FY 81-82	\$20,693,921	\$10,023,822	N/A	\$919	10,911	4. Average based on 33 jurisdictions with data in both "Total DOC Expenditure" column and "Total Health Expenditure" column.
IL	1982	\$9,743,800	\$934,638	4.5%	\$704	1,328	
IN	1982	\$33,456,926	\$1,005,985	10.3%	\$984	2,768	
KS	FY 81-82	\$81,839,187	\$5,627,100	6.9%	\$588	9,570	
LA	FY 82	\$20,942,716	\$1,051,045	5.0%	\$1,095	9,233	
ME	FY 82	\$80,814,994	\$6,307,837	7.8%	\$1,053	6,027	
MD	FY 82	\$37,848,489	\$2,098,953	5.5%	\$927	2,215	5. Weighted average based on all 36 jurisdictions reporting.
MI	FY 82	\$26,000,000	\$2,000,000	7.7%	\$513	4,685	
MS	FY 82	\$46,000,000	\$2,800,000	6.1%	\$473	5,918	
MO	FY 82	\$18,217,352	\$532,718	2.9%	\$710	750	
MT	1982	N/A	\$1,800,000	N/A	\$1,216	1,480	
NE	1982	\$5,500,000	\$741,635	13.5%	\$1,648	450	
NH	FY 81-82	\$46,300,000	\$2,120,000	4.6%	\$1,247	1,700	
NC	FY 82	\$158,064,666	\$16,867,249	9.4%	\$866	16,766	
ND	1982	\$8,600,000	\$105,620	1.2%	\$1,311	800	
OR	FY 82	\$82,391,609	\$4,670,927	5.7%	\$935	4,996	
OK	FY 81	\$36,244,529	\$3,022,010	8.3%	\$1,017	2,953	
PA	FY 81-82	\$108,450,000	\$10,000,000	9.2%	\$1,017	9,505	
RI	FY 82	\$23,378,931	\$1,664,830	7.1%	\$836	990	
SC	FY 82	\$54,318,609	\$5,104,866	9.4%	\$1,682	8,602	
SD	1982	\$6,422,632	\$358,147	5.6%	\$532	6,673	
TN	FY 81-82	\$64,535,361	\$5,044,587	7.8%	\$737	6,842	
TX	FY 81-82	\$264,974,355	\$12,791,735	4.8%	\$395	32,744	
VA	1982	\$103,864,322	\$4,875,758	4.7%	\$656	7,771	
VT	1982	\$117,010,700	\$4,206,253	3.6%	\$496	2,575	
WY	1982	\$12,892,975	\$82,000	0.6%	\$479	797	
WV	1982	\$178,007,875	\$34,000,000	19.1%	\$1,216	28,700	
WY	1982	\$81,363,062	\$5,783,922	7.2%	\$803	6,548	

\*CODES NOT INCLUDE FL, IL, IN, IA, KY, MA, MI, MN, NJ, NY, OH, UT, VT, WA, WY

TABLE A-7  
COMPARISON OF CORRECTIONAL HEALTH SERVICE  
COSTS BY STATE (1985)

STATE*	YEAR*	TOTAL DOC EXPENDITURE	TOTAL HEALTH EXPENDITURE INCLUDING MENTAL HEALTH	% OF TOTAL DOC EXPENDITURE DEVOTED TO HEALTH	ANNUAL HEALTH COST PER INMATE	ANNUAL TOTAL INMATE POPULATION	NOTES
AL	1985	\$102,105,263	\$9,700,000	9.5%	\$1,239	7,829	1. This table was derived from data published by
AK	FY 85	\$172,972,973	\$5,500,000	3.2%	\$2,423	2,229	Contact, Inc., XI Corrections Compendium 1: 7,13-14
AZ	1985	\$116,000,000	\$5,300,000	4.6%	\$1,269	7,329	(July, 1986).
CA	1985	\$38,281,250	\$4,900,000	12.8%	\$1,072	4,571	
CO	1985	N/A	\$69,000,000	N/A	\$1,893	47,015	2. Average based on the 39 areas with data.
CT	1985	\$60,317,460	\$3,600,000	6.3%	\$1,317	2,685	
DE	1985	\$97,727,273	\$4,300,000	4.4%	\$757	5,680	3. Average based on all 46 jurisdictions reporting.
FL	FY 84	\$43,478,261	\$2,000,000	4.6%	\$1,150	1,739	
GA	1985	\$343,902,439	\$28,200,000	8.2%	\$1,004	28,088	4. Average based on 39 jurisdictions with data in both
IL	1985	\$191,208,791	\$17,400,000	9.1%	\$1,259	13,620	"Total DOC Expenditure" column and "Total Health
IN	1985	\$29,850,746	\$2,000,000	6.7%	\$982	2,037	Expenditure" column.
IO	FY 86	\$16,853,933	\$1,500,000	8.9%	\$1,150	1,272	
LA	1985	\$289,705,882	\$19,700,000	6.8%	\$1,150	10,521	5. Average based on all 36 jurisdictions. This figure
MA	1985	\$127,619,048	\$13,500,000	10.6%	\$1,276	10,501	differs from the one reported by Contact, Inc. because
MD	FY 85-86	\$40,645,116	\$2,600,000	3.7%	\$576	4,861	here a weighted average was used.
ME	1985	\$110,975,610	\$1,300,000	8.2%	\$801	11,361	
MI	1985	\$170,129,070	\$13,100,000	7.7%	\$1,161	1,120	6. Average based on all 46 jurisdictions.
MN	1985	\$132,926,829	\$10,900,000	8.2%	\$1,019	12,856	
MO	FY 86	\$45,822,785	\$5,200,000	7.9%	\$1,725	6,319	
MS	1985	\$48,571,429	\$3,400,000	7.0%	\$609	5,383	
MT	1985	\$13,515,436	\$743,349	5.5%	\$772	1,963	
NE	1985	\$40,000,000	\$2,200,000	5.5%	\$1,160	1,963	
NH	1985	\$15,153,868	\$1,900,000	12.6%	\$1,044	3,750	
NJ	1985	\$15,153,868	\$1,900,000	6.5%	\$1,448	680	
NM	1985	\$15,153,868	\$1,900,000	N/A	\$800	12,500	
NY	1985	\$635,416,667	\$30,500,000	4.8%	\$2,600	2,115	
NC	1985	\$216,666,667	\$23,400,000	10.8%	\$901	33,851	
ND	1985	\$5,296,552	\$307,200	5.8%	\$1,398	16,728	
OH	1985	N/A	\$11,100,000	N/A	\$555	439	
OK	FY 84	\$71,084,337	\$5,900,000	8.3%	\$688	6,095	
OR	1985	\$46,575,342	\$3,400,000	7.3%	\$1,173	2,899	
PA	FY 84-85	\$160,869,565	\$14,800,000	9.2%	\$1,764	12,369	
RI	1985	\$27,500,000	\$2,200,000	8.0%	\$726	3,049	
SC	1985	\$97,000,000	\$1,000,000	4.0%	\$717	5,439	
SD	1985	\$13,151,895	\$1,000,000	7.5%	\$1,039	962	
TN	1985	\$125,000,000	\$10,500,000	6.0%	\$1,300	8,077	
TX	1985	\$1,000,000,000	\$51,000,000	5.1%	\$1,700	30,000	
UT	1985	\$16,486,466	\$410,000	3.7%	\$1,010	604	
VA	FY 85	\$152,631,579	\$2,900,000	1.9%	\$461	6,291	
WV	1985	\$18,750,000	\$1,500,000	8.0%	\$1,014	1,479	
WI	1985	N/A	\$5,400,000	N/A	\$1,019	5,299	
WY	1985	\$14,057,563	\$674,763	4.8%	\$800	843	
WY	1985	\$519,318,182	\$45,700,000	8.8%	\$1,459	31,380	
WY	1985	\$140,473,842	\$10,852,615	6.0%	\$1,728	6,291	

\*NOT INCLUDING KS, MI, MO, UT, VA.; \*\*FIGURES ARE FOR 1985 CALENDAR YEAR UNLESS OTHERWISE NOTED BY FISCAL YEAR



### APPENDIX 3.—STATEMENT OF AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

American Federation of Government Employees, AFL-CIO

Task Force Report on:

#### PRIVATIZING FEDERAL PRISONS

##### Critical Considerations

The Bureau of Prisons is a model agency with respect to carrying out its mission. Bureau of Prison Personnel are viewed as dedicated and highly skilled employees who consistently perform their duties in an effective and exemplary manner. In short, there is absolutely no evidence which indicates that the Bureau of Prisons should be significantly reorganized or eliminated or that private prison contractors should replace current employees. Indeed, all of the evidence suggest just the opposite.

Further, it is well documented that very little savings results from contracting for the management and control of prisons.

Therefore, the philosophical premise that privatizing government functions is in the public interest, has no validity with respect to Federal prisons and any proposal to privatize the management and control of Federal prisons is not well-founded.

This report identifies those issues which must be carefully scrutinized prior to taking any action to expand the private sector role in federal corrections by contracting for the management and operations of some, or all federal prisons.

#### INTRODUCTION

The prison population throughout the United States has steadfastly increased at an alarming rate. For example, it rose

from 300,000 in 1980 to 500,000 in 1985.<sup>1</sup> The Federal prison population is approximately one-third of the overall prison population and it has increased at just as an alarming rate. As of April 3, 1995, it was nearly 97,300<sup>2</sup>, an increase of nearly 8% over the preceding fiscal year. Long-range forecasts project that the total Federal prison inmate population will reach 136,000 by the year 2002.

This dramatic increase in the prison population and the projected continued increase is attributable to several factors the most notable being the Federal sentencing guidelines, reduced "good time" allowances, and mandatory minimum sentences all of which increase the amount of time the average inmate must serve in prison.

The prison population is changing too. In 1994, 61 percent of the inmates were incarcerated for drug related offenses and this number is expected to rise an additional nine percent by the end of 1996. Criminal aliens represent approximately one-quarter of the inmate population. These populations are difficult and dangerous and the custody of these individuals has placed increased demands on Bureau of Prison personnel as well as it has resulted in overcrowding at many facilities.

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<sup>1</sup> John D. Donahue, Prisons for Profit: Public Justice, Private Interests, Economic Policy Institute, 1988 at 4.

<sup>2</sup> Statement of Kathleen M. Hawk, Director, Federal Bureau of Prisons, before the Senate Subcommittee on Appropriations for the Departments of Commerce, Justice, and State, the Judiciary and related Agencies.

In response to the rise in the prison population, the Federal government has had to increase expenditures in order to meet its obligations of providing for the health and welfare of its inmates. These expenditures have come under scrutiny in the current political climate which has focused its efforts on reducing the role of government and cutting expenditures.

The role of Bureau of Prisons personnel is not confined solely to the care and custody of Federal inmates. It has been expanded substantially by Congressional action.

In 1968, Congress enacted Section 4042 of title 18, United States Code, expanding Bureau of Prisons' authority to provide technical assistance to State and local governments in the improvement of their correctional systems. In addition, the BOP has the power to disseminate information on correction policies and techniques. The statute's legislative history indicates that State and local government's enlisted the assistance of the BOP because their specialized training makes them uniquely qualified to provide specialized services to State and local governments. The BOP's corrections personnel are among the best trained and well equipped in the world.<sup>3</sup>

Prior to enactment of 18 U.S.C. §4042, the BOP had limited authority to provide assistance to State and local governments which requested their help. Thus, BOP's expanded authority under the direction of the Attorney General, has aided State and local

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<sup>3</sup> S. Rep. No. 1285, 90th Cong., 2nd Sess. at 2463 (1968).

governments in providing suitable quarters for the safekeeping, care and subsistence of all persons charged with or convicted of offenses against the United States, provided for the protection, instruction, and discipline of all persons charged with or convicted of offenses against the United States, and provided technical assistance to State and local governments in the improvement of their correctional systems.<sup>4</sup> But, this has increased the overall cost to the Federal government of maintaining its Federal prison system.

As a result of the increased costs due primarily to the prison population increase but also attributed to Bureau of Prisons's expanded role in assisting states, President Clinton's budget for FY 96' has slated four new minimum and low security prisons to be operated by private corrections companies. This represents a major shift in policy.

On its face privatizing prisons appears to be a viable alternative in order to cut costs and reduce federal expenditures. However, evidence suggests that privatizing prisons is an ineffective alternative to public operation in a number of ways:

- \* First, operating prisons for profit represents a conflict of interest.
- \* Second, private prison corporations are not meeting projected savings. Furthermore, evidence suggests that the two major corporations which represent the lions

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<sup>4</sup>18 USCA Section 4042.

share of the market<sup>5</sup>, the Correction Corporation of America (CCA) and Wackenhut Corporation are both operating at a loss<sup>6</sup>. These losses, many fear, will eventually be passed onto the State and pose an additional risk of a bankrupt contractor unable to fulfill its cost obligation.

- \* Third, cost-cutting often results in cutting services, (i.e. the number and quality of security guards).
- \* Fourth, the hiring of less qualified guards jeopardizes security and hence, citizens in communities adjacent to federal prisons.
- \* Lastly, the government remains liable for any lawsuits that arise while an inmate is under the care of private prison facilities. This obligation to insure the constitutional rights of inmates remains the responsibility of the Government even when the care and custody of inmates is contracted out.

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<sup>5</sup> The Corrections Corporation of America operates 23 facilities under contract. The Wackenhut Corrections Corporation operates 18 facilities under contract. Seventeen other corporations run private prisons, however, none of the other corporations operate more than eight private prison facilities per corporation.

<sup>6</sup> The Corporation of America has lost money in every year since it began reporting results in 1984 for an aggregate loss of 6.8 million on revenues of 24 million. John D. Donahue, Prisons for Profit: Public Justice, Private Interests, Economic Policy Institute, 1988 at 12.

As of December 31, 1994, Wackenhut reported a net income loss of \$1,384,000 and earnings per share of \$.14 compared to revenue of \$664,160,000 net income loss of \$2,165,000 and earnings per share of \$.22 for the comparable period in the prior year. Dunn & Bradstreet, Business Information Report (1995).

**PRIVATE PRISONS FOR PROFIT: A CONFLICT OF INTEREST**

Operating prisons for profit represents a conflict of interest because of the nature of services that prison officials provide. Prior to the push for privatization, the federal government maintained a very specialized role in providing a safe and secure environment that not only adequately protected the Constitutional rights of prisoners but also protected the welfare and safety of the surrounding community. In addition, the legislative history of amendments to the statute indicates that the BOP's augmented authority originated from a critical need of state and local officials to receive technical assistance from the BOP. Because the BOP provides specialized and technical services maintaining the health, welfare and safety of its inmates and the surrounding community, their services are and should be preserved as a public function. Providing for the health, welfare and safety of inmates and the surrounding community are services which should not be provided for profit because that goal is often sacrificed in the quest to realize profits--too few guards hired with minimal qualifications at low pay--is the classic example of increasing the profit margin at the risk of the public and the inmates.

**THE COST EFFECTIVENESS OF PRIVATIZATION**

The proposal to relinquish the traditional public prison operation functions to private institutions was formulated in response to a need to cut expenditures and save taxpayers money. However, years of state experience in privatizing prison operations has yielded, thus far, little evidence to suggest that private

prisons actually save the government money. For example, the Corrections Corporation of America, (CCA), projected a 12.5% saving over the cost of county management when it took over the Silverdale Work Farm in Tennessee.<sup>7</sup> However, a comparison study of the private prison run by CCA and two other state operated facilities found that the CCA facility was only one percent cheaper than state run facilities.<sup>8</sup> Furthermore, CCA has lost money in every year since it began reporting results in 1984. These losses, many fear, will be shifted to the state through an increased contract price to cover those losses.<sup>9</sup> Moreover, the second largest private prison corporation, (Wackenhut), is also operating at a loss reporting a net income loss of \$1,384,000 and earnings per share of \$.14.<sup>10</sup> These losses, like CCA's, could conceivably be recouped in the contract price. But, more importantly the risk to the public and to the inmates of a contractor who declares bankruptcy and fails to perform by providing guards is self evident. In sum, it appears that the cost savings that private prisons project are minimal at best and that the attendant risk is extremely high.

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<sup>7</sup> John D. Donahue, Prisons for Profit: Public Justice, Private Interests, Economic Policy Institute 1988 at 12.

<sup>8</sup> Linda M. Lampkin, Does Crime Pay? AFSCME Reviews the Record on the Privatization of Prisons, 7 Journal of Contemporary Criminal Justice 1, March 1991.

<sup>9</sup> Warren Cohen, Where Privatization May Not Pay, U.S. News and World Report, April 3, 1995 at 48.

<sup>10</sup> Dunn & Bradstreet, Business Information Report (1995).

CUTTING COSTS, CUTTING SERVICES:REDUCING THE NUMBER OF GUARDS

Many times the impressive numbers quoted in conjunction with the cost effectiveness of privatization are achieved at the expense of services. One such service that has suffered in the face of privatization is the number of guards hired to man the prisons. For example, the CCA slashed 17% of its staff when it assumed control of the Hernando County, Florida jail. Under federal control, the prison maintained a staff of 94 persons. Under CCA control, the staff has been reduced to 78. Wackenhut's private prison in Monroe County, Florida, failed to meet the minimum state requirement of 11 manned posts. Served with a deficiency notice from the State, the corporation increased its manpower to roughly eight officers at a time not by employing additional guards but by installing video cameras which conducted electronic patrols. The facility was dangerously understaffed and both the prison population and the surrounding community threatened.

On April 3, 1995, an article in U.S. News and World Report stated that "cost pressures could also force private prisons to cut back on services like the number of guards, which could affect safety."<sup>11</sup> Under-staffing presents numerous problems which have severe repercussions for inmates, the surrounding community and the federal government. Under-staffing leads to inadequate monitoring of inmates. This in turn affects security. It is, therefore,

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<sup>11</sup> Warren Cohen, Where Privatization May Not Pay, U.S. News and World Report, April 3, 1995 at 48.



extremely easy to see the severe repercussions that under-staffing has for all parties involved.

#### THE HIRING OF LESS QUALIFIED GUARDS--TRAINING

Another way in which private prisons cut costs is by hiring "less qualified" guards. These guards are decidedly "less qualified" when compared to federal guards hired to perform the same functions. Federal guards are specially trained at Glencoe, the federal police training facility; more likely to be high school graduates; work full-time and year-round at their jobs, and are of prime working age.<sup>12</sup> They are career employees while the high turnover rate of guards employed by contractors suggests they are anything other than dedicated career employees.

The hiring of "less qualified" guards contravenes the intent of Congress in augmenting the authority and responsibility of the Bureau of Prisons. Congress sought to utilize members of the BOP because they are the best qualified to disseminate information and provide technical assistance to State and local governments. When private firms employ less qualified guards the government, the states and local communities, and the American public lose that expertise.

When private firms employ less qualified guards who are not specially trained for the position, they often cannot adequately contain or put down uprisings or other problems that specially trained federal guards encounter and contain. Thus, less qualified

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<sup>12</sup> John D. Donahue, Prisons for Profit: Public Justice, Private Interests, Economic Policy Institute, 1988 at 15.

guards affect the safety of prison personnel, inmates and the surrounding community.

THE HIRING OF LESS QUALIFIED GUARDS--COMPENSATION

Low wages contribute to the low quality of the guards who man the posts at private prisons. There is ample evidence which suggests that there is a direct link between the salary that private guards receive and the quality of the guards hired.<sup>13</sup> Taken in the aggregate, federal prison personnel earn more than private prison personnel: private security guards earn 15% less than do public correctional workers.<sup>14</sup> Low wages affect prisons in two ways. One, it results in a high turnover rate (in Arizona among private prisons it is 22% a year). Two, since the jobs do not pay as well, less qualified personnel, (i.e. lower educational levels), fill the positions. Currently, the Governor of Arizona is attempting to implement a program to increase state salaries in order to recruit more qualified personnel. It is apparent that there is a direct relationship between the salaries paid and the quality of guards retained. It is also obvious that contractors paying low wages in order to increase profits will employ the least skilled and trained individuals. This contradicts the very reason that State and local governments privatize their functions because the State, (e.g. Arizona), now has to expend money to recruit qualified personnel. It is apparent that this expenditure would be

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<sup>13</sup> Id. at 15.

<sup>14</sup> Id. at 15.

unnecessary if the specially trained and well equipped federal prison personnel remained available.

POORLY PAID LESS QUALIFIED GUARDS

AND THE EFFECT ON SAFETY AND SECURITY

Poorly paid, less qualified guards also affect safety and security. For example, residents near the privately operated Detention Center at Eloy, Arizona, run by Concept, Inc. of Louisville, KY, demanded that more experienced guards be hired after there was a second violent uprising at the prison in less than three weeks. The citizens complained of inexperienced and unqualified guards who were not trained to handle such problems.<sup>15</sup> Likewise, CCA's medium security South Correctional Center in Clifton, Tennessee has also experienced safety problems. One inmate was killed and two others were seriously injured after a stabbing. An inmate was found with a handgun after a search. Furthermore, there have been numerous problems with inadequate security which have contributed to many escapes. For example, during a twenty month period at CCA's Hamilton County, Tennessee Penal Farm, thirteen inmates escaped from the facility itself. During an eight month period in 1986, twenty-three inmates escaped from the road crew. Thus, it appears that the cost savings that private prisons project are often achieved by cutting costs through personnel, services, etc. The ramifications of cutting personnel and services are tremendous because these cuts are often at the

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<sup>15</sup> Norman Peckham, Prison Uprising Puts Eloy on Edge, Tuscon Citizen, November 15, 1994.

expense of the safety and security of prison personnel, inmates, and the surrounding community. It leaves one to ask "Are we really cutting costs if we are sacrificing safety?"

### THE LIABILITY FACTOR

Governments in many instances are still liable for damages that arise while inmates are under the care of private prison contractors. "Contracting out prison medical care does not relieve the State of its Constitutional duty to provide adequate medical treatment for those in custody, and it does not deprive the State's prisoners of the means to vindicate their Eighth Amendment rights. The State bore an affirmative obligation to provide adequate medical care to the inmate; the State, (North Carolina), delegated that function to the respondent; the respondent voluntarily assumed that obligation by contract."<sup>16</sup> "North Carolina should not be permitted to plead a lack of responsibility because it delegated that task to a private party."<sup>17</sup> Thus, although many of the functions that federal officials assume have been delegated to private corporations legally have been. The federal government still has an affirmative duty to uphold prisoners' Constitutional rights. This includes providing adequate and accessible health care, providing sanitary conditions, and offering inmates sufficient programmatic activity. Therefore, private prisons could inevitably cost taxpayers more money because federal officials

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<sup>16</sup> Robbins, I.P., The Legal Dimensions of Private Incarceration, American Bar Association 117 (1988).

<sup>17</sup> West v. Atkins, 815 F.2d 993, 1000 (1987).

still have the same obligations to inmates and because it does, it is liable for damages which emanate from the breach of that duty by private prison contractor corporations.

#### CONCLUSION

Private prisons are touted as the answer to the rising cost of detaining and housing inmates. However, there is little evidence to suggest that private prisons are a viable alternative to publicly operated prisons. Thus far, the evidence suggests just the opposite. The cost savings that private prisons project are deceiving because private prisons often cut costs to save money and at the same time increase the profit margin. Cutting costs have taken numerous forms, i.e., private prisons have reduced the number of guards. This has serious repercussions because it ultimately affects the safety of inmates, prison personnel and the surrounding community.

Private prisons have cut costs by hiring less qualified guards with lower educational levels for less money. Hiring guards that are not well educated or specially trained for less money, likewise, jeopardizes the health, and safety of prison personnel, inmates and the surrounding community because these guards are not equipped to handle uprisings or violent insurrections.

Finally, the government still has an affirmative duty to uphold the constitutional rights of inmates. This cannot be delegated.

For all of these reasons and in light of the numerous problems that private prisons present, the push for privatization must be

carefully considered and scrutinized. When this is done, the only conclusion which can be reached is that the management and operation of Federal prisons is a core governmental function. As such, it must be undertaken by federal employees who are highly qualified and specially trained. The Bureau of Prisons' personnel meets that criteria. So, in conclusion, there is absolutely no rational basis which would support action to privatize federal prisons.

## ACKNOWLEDGEMENTS

The development of this report was a joint effort of the AFGE Bureau of Prisons Council 33 and AFGE's Bureau of Prisons Staff Task Force. We would especially like to extend appreciation to:

Sandra Sue Adams-Choate, Assistant General Counsel,  
Chair, AFGE's Staff Task Force  
Beth Moten, Director, Legislative Department,  
AFGE's Staff Task Force  
Rosalind Kennedy, Legal Intern, General Counsel's Office,  
AFGE's Staff Task Force  
Philip W. Glover, NE Regional Vice President,  
National Legislative Representative  
AFGE Council of Prison Locals 33

for their input and effort into the preparation of this document.

American Federation of Government Employees, AFL-CIOFACT SHEETPRIVATIZING FEDERAL PRISONSCritical Considerations

- FACT:** Donald F. Kettl, the Brookings Institution, states long experience has shown that while almost any function can be privatized, core functions essential for ensuring effective government and the public interest should not be privatized.
- FACT:** President Clinton recommends expanding the private sector role in Federal Corrections by contracting for the management and operations of four Federal prisons currently under construction.
- CONCLUSION:** The management and operation of Federal prisons is a core function which, in the public interest, should not be privatized.
- FACT:** Kathleen Hawk, Director, Bureau of Prisons, explains President Clinton's proposal will contribute to the Administration's effort to reduce the number of Executive Branch employees.
- FACT:** The National Performance Review reports that it is not interested in promoting privatization simply to make FTE reductions but rather, privatization is a tool to restore the public faith by managing resources more effectively. Therefore, privatization decisions must improve customer service and cost less.
- FACT:** John D. Donahue, Economic Police Institute, notes there is little evidence to suggest that contractor-operated prisons save money.
- CONCLUSION:** No valid rationale is propounded for utilizing contractors for the management and control of Federal prisons. Therefore, those functions should not be privatized.
- FACT:** The National Performance Review reports privatization implies the government is currently providing the service, but no longer sees the need to be in direct control of its provision, operations or maintenance.
- FACT:** U. S. News and World Report found that profit motives can force contractor-operated prisons to reduce the number of guards at a facility which affects inmate and community safety.



**FACT:** Norman Peckham, reported in the Tucson Citizen on the uprising at the Eloy, Arizona contractor operated prison, the citizens believed that the inexperienced and unqualified guards hired by the contractor were not trained to handle serious problems such as uprisings.

**CONCLUSION:** The conflict of interest which arises between a contractor's desire for profit and the necessity of providing a sufficient number of well trained and justly compensated prison guards mandates that Federal prisons be managed and controlled by Federal employees.

**FACT:** The Courts have held the government has an affirmative obligation to uphold the constitutional rights of those in custody including providing adequate medical treatment. Further, the Government is not relieved of this obligation when it contracts for prison operations.

**CONCLUSION:** Management and control of Federal prisons must remain a Government function.

#### **IT'S UP TO YOU**

Based on the FACTS set forth above, which are more fully explained in the accompanying report, there are no valid arguments which support the privatization of Federal prisons.

We ask for your support in urging the passage of measures which will insure that the core governmental function of managing and controlling Federal prisons is undertaken in the best interests of the American public at the lowest possible cost. This governmental obligation can only be accomplished by Bureau of Prisons personnel--those highly qualified, skilled and trained for the job who have no ulterior profit motives but only the motives of loyal and dedicated career employees.

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APPENDIX 4.—STATEMENT OF FEDERAL PRISON COUNCIL 33, AFGE,  
AFL-CIO



FEDERAL PRISON COUNCIL 33  
(AFL - CIO)

WHY CONTRACTING FEDERAL PRISONS IS BAD FOR THE COUNTRY

1. **CONTRACT PRISONS WILL NOT SAVE TAXPAYER DOLLARS!**

A corporation cannot operate a Federal Prison under the same regulations and requirements as the Federal Bureau of Prisons and still show a profit. WHO will pay the costs for an increase in lawsuits by inmates when they are not properly housed, fed, counseled, protected and/or supervised?

2. **CONTRACT PRISONS ARE POTENTIALLY UNSAFE!**

The Bureau of Prisons has the ability to respond to a disturbance in their institutions with highly trained, experienced staff. These individuals can be transported to an institution on short notice, if necessary, and coordinate their efforts with others who have similar experience and training. WHO will a contract prison call if they need assistance? HOW MUCH will that assistance cost the taxpayer?

3. **CONTRACT PRISONS DO NOT BENEFIT THE COMMUNITY TO THE LEVEL THAT A FEDERAL PRISON WOULD!**

Communities where Federal Prisons are to be located have been "promised", by the Bureau of Prisons, that "good paying, Federal jobs" would be available to members of the affected communities as an incentive to locate a Federal Prison in their areas. Some of these communities have invested millions of dollars to facilitate these institutions. A contract prison cannot provide these same incentives and still make a profit. WHO will offset the expenses incurred by these communities? WHO will make good on the Bureau of Prisons promises?

4. **CONTRACT EMPLOYEES ARE NOT BOUND BY FEDERAL LABOR LAW!**

Employees in the Federal Bureau of Prisons are prevented from going out on strike or taking any other kind of job action. Contract employees are not restrained from these and other

actions. WHO will operate a contract facility if the employees strike, walk out or take other disruptive actions? HOW much will it cost to hire, train, and replace workers if these type of actions take place?

**5. CONTRACT EMPLOYEES DO NOT HAVE TO PASS A COMPREHENSIVE SECURITY/BACKGROUND INVESTIGATION!**

Unlike employees of the Federal Bureau of Prisons, contract employees do not have to pass a comprehensive security/background investigation. This lack of proper security could lead to an individual who is a convicted felon, a person of questionable character, or a person with a "checkered" work history being employed in a contract facility. IF the Bureau of Prisons were not required to perform "background" investigations, they too could be more competitive and "cost effective". HOWEVER, the caliber of the Bureau's employees would also diminish!

**6. CONTRACT PRISONS CANNOT COMPETE WITH OTHER STATE/FEDERAL PRISONS, CAUSING STAFFING SHORTAGES WITHIN INSTITUTIONS!**

By paying a lower wage and not providing benefit packages, contract prisons will be in danger of being unable to staff their facilities. NO contract facility can compete with the State/Federal prison systems in terms of pay and benefits. Without competitive pay and benefit packages, contract prisons cannot attract high quality employees. WITHOUT high quality employees, contract facilities cannot operate effectively and efficiently.

**AS YOU CAN SEE, CONTRACT PRISONS ARE NOT GOOD FOR THE COUNTRY, THEY ARE ONLY GOOD FOR THE PEOPLE WHO HOLD THE CONTRACTS!**

For more information, please contact;

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# Comment

The Arizona Daily Star

Founded 1877

Stephen E. Auslander, Editor  
James M. Kiser, Editorial Page Editor

Michael E. Peltzer, Publisher

## EDITORIALS

### Underpaid prison guards

The governor is convinced that Arizona's prison guards need pay raises to avoid a crisis in the state prisons, and the argument for increases is strong enough to convince the Legislature to go along with his recommendations.

But as legislators read the reports from prison officials and listen to their testimony supporting the pay raises, they should also recognize a nascent problem with the current push for privatization of the prison industry. Guards in privately run prisons are younger, are paid less, and are trained less than the ones in the state system. If the state system is at a crisis, the private prisons are inviting catastrophe.

Evidence of the problem occurred twice recently at the Elroy Detention Center, a federal prison that houses mostly immigration violators and is run by a private company called Concept Inc. The center has been the scene of two riots in the first five months of operation. It hires recent high school graduates, trains them for two weeks, and pays them \$6.87 an hour, according to a recent article in The Christian Science Monitor. Those with more experience make a whopping \$8.46 an hour.

Arizona, meanwhile, has a hard time recruiting and keeping its guards at a relatively more generous rate. About 76 percent of Arizona's guards earn \$21,000 a year, or about \$10 an hour.

But it's still low pay for a tough, dangerous job. The turnover rate is 22 percent a year, according to the Department of Corrections, which has had to loosen promotion standards and lower minimum requirements

to fight a 12 percent rate of unfilled jobs.

"If the problem should continue where the prison population increases at a net rate of 100 a month, and we continue to lose corrections officers, it stands to reason that security problems are going to become more prominent — violence, escapes, drug smuggling," a spokesman told the Associated Press.

The governor wants to accelerate promotion and pay raises so that most guards will be able to earn at least \$25,000 a year within five years of being hired.

That certainly should be done.

And the Legislature should heed the other message here: There is no cut-rate solution to the cost of punishment. Officials at the Elroy Detention Center said the riots there occurred because inmates objected to the lack of Mexican food and poor Spanish-language television reception.

But present and former guards told a different story to the Monitor.

In order to meet a budget that is \$10 per day per inmate less than comparable federal facilities, Elroy was cutting corners on supplies as well as hiring guards who were too young, too poorly trained and woefully underpaid, the guards said.

If that is how private prisons save money, it is a false economy.

You don't save money when you must periodically muster every available law-enforcement officer in the state to put down riots. And a cheaply run, unsafe facility will cost you more in injury, death and lawsuits than it will ever save.

2/4/94  
Tucson, AZ



Testimony of Philip W. Glover  
 Council of Prison Locals  
 American Federation of Government Employees  
 before the  
 United States Congress  
 Subcommittee on Appropriations for  
 Commerce, Justice, State, the Judiciary and Related Agencies  
 May 11, 1995

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you today on behalf of the 22,000 Bureau of Prisons Employees represented by the Council of Prison Locals. We would like to present our views to the Subcommittee on the proposed FY 1996, Federal Bureau of Prisons budget request. Let me begin by expressing my appreciation for the opportunity to speak today. I would like to begin with a short opening statement and place the remainder of my material into the record. I would like to explain to the committee that although I am a representative of the Union, I am also a correctional officer who works in a Federal Prison daily.

The fiscal year 1996 budget request totals \$2,977,645,000, this request includes 32,412 positions and 31,290 work years (FTEs). Although this seems like a large amount of positions, in reality the Federal Prison system is short staffed. At institutions throughout the country, correctional officer's posts (places of duty) are being vacated. We as a Union are told consistently, that there is no more money for positions. Yet, when the Director of the Federal Bureau of Prisons testified recently in a similar subcommittee hearing, she stated that she had requested enough money to operate the Federal Bureau of Prisons safely and securely. The statistics indicate that assaults on staff members within the prison system is on the rise.

We believe that Federal Prison workers deserve an increase in staffing levels for a constant increase of new inmates into our system. Currently, it has been proposed that the Federal Bureau of Prisons take over the operation of Lorton Prison in the District of Columbia. This would increase the inmate population by approximately 7,000. However, there has been no proposal for an increase in staff to handle the influx of these inmates. Once again, Bureau employees are asked to handle difficult, violent, and disruptive inmates without the benefit of an increase in staff. Our prisons are currently at 25% over capacity, with 97,430 inmates in the system. These inmates have changed from predominately non-violent white collar criminals to drug dealers, rapists, mafia/gang members and murderers.

The current trend towards reinvention of government has the Federal Bureau of Prisons reducing staff across the board at 8% by 1998. The Bureau's Financial Management and Human Resource Departments are being cut 25% by 1998, as well. What has not been pointed out to the Vice-President of the United States and Congress is that these personnel work inside the fences and walls of prison facilities. They respond daily to emergency situations such as body alarms, fire alarms, assaults, fights, and murders. By not exempting the Bureau of Prisons from these reductions, it is believed that staff safety will be jeopardized. It is ironic that in a time of increased pressure on Congress to reduce crime in our streets that we would allow a decrease in prison staffing levels. The 104th Congress recently passed a series of changes to crime legislation including restricted minimum mandatory sentences, no frills legislation, three strikes your in and

removed judicial caps on inmate capacity. Again, prison employees are not receiving increases; they're receiving decreases in staffing levels.

While the Director of the Bureau of Prisons (BOP), Kathleen M. Hawk, provided a variety of information, both in writing and orally, regarding the BOP's efforts to "reinvent" government, of specific concern to the Council of Prison Locals (CPL) is the proposal contained within the BOP's 1996 budget for the "privatizing" or "contracting out" of various Federal Prisons.

The purpose of reinvention is to reduce the cost and size of the Federal Government. It was made clear at the Subcommittee Hearing, by Director Hawk, that no cost studies had been performed by the BOP on the subject of "contracting" prisons.

Additionally, Director Hawk indicated that there was no data available to indicate whether or not "contracting" prisons would be cost effective.

We submit that there is a wealth of information available, both in the federal sector and within various states, to either prove or disprove the economic feasibility of "contracting" prisons. These studies should be accomplished prior to implementation of any contracting of institutions.

Although Director Hawk "briefly" spoke about the contract prison in Eloy, AZ, that institution has been in operation for approximately one year. During that operations period, there have been two (2) significant disturbances which resulted in property damage and injury to staff and inmates.

While the Eloy facility has not been forthcoming publicly, regarding the level of damage to the facility, nature and severity of the injuries to staff and inmates, lawsuits brought about due to the disturbances and general conditions and operation of the facility, it is reasonable to believe that, given the history of similar situations in BOP facilities, the cost of all of these actions was substantial.

As Senator Bumpers so appropriately put it, when Director Hawk indicated that there was no data to indicate an overall cost savings, the proposed "contracting" of Federal Prisons was akin to using these identified facilities, specifically the institution in Forrest City, AR, as "guinea pigs".

Therefore, sufficient data "should" exist to prove whether there will be a significant cost savings.

As an example, Wackenhut Corrections, Corporation operates a range of facilities throughout the country. According to a Dun & Bradstreet Information Report, as of 2/16/95, the company experienced a net income loss of \$2,193,000 and earnings per share of \$0.30 compared to a net income loss of \$795,000 and earnings per share of \$0.12 for the comparable period in the prior year. A Composite Credit Appraisal indicates an overall "fair" credit appraisal by Dun & Bradstreet.

Is the intent of contracting out Federal Prisons to save the government money, provide a higher quality service or to provide private companies with short term increase revenue?

The Federal Prison System has just completed approximately sixty (60) years of service to the taxpayers of the United States. During those years, the training, regulations, policies, and staffing guidelines for operating prisons has evolved.

The requirements in place today are due to experiences learned from the past, some of these experiences that left Bureau staff severely injured or dead. The Council of Prison Locals would like to bring some of these concerns to the Subcommittees attention.

Currently, Federal Bureau of Prison employees are required to attend three weeks of training at the Federal Law Enforcement Training Center in Glynnco, GA. Included in this training, are firearms, unarmed self-defense techniques, proper procedures for the use of force, application and use of restraints, oral and written communication techniques, and other important information. Annually, employees are required to attend refresher training at their local institutions on the above-mentioned subjects.

( Will Contract Prison Workers be held to the same standard? If so, who will pay for this requirement? )

Prison employees are investigated by Office of Personnel Management, this inquiry goes back fifteen (15) years. Employees are then subject to five (5) year updates. This is to prevent employees from being manipulated by inmates.

Will Contract Prison Workers be held to the same standard? If so, who will pay for this requirement? Also, what Agency will perform the investigations?

Federal Prisons are staffed according to American Correctional Association standards. This, in the past, has been very important to the Bureau. Where will "contract" prisons compare under these "ACA" standards? Or will these standards be conveniently scrapped to facilitate "contracting" prisons?

Further, the Federal Bureau of Prisons is required to provide a variety of "mandated" services from Drug Treatment and Counseling to Recreational and Education opportunities. If "contract" prisons are not required to provide these, and other, services, how can a contracted facility be fairly compared to a BOP facility in the terms of cost effectiveness? If various BOP facilities, such as those which have been identified for "contracting out", were not required to provide these services, then the employees of the BOP could also show a significant cost savings in the overall operation of an institution.

As you may be aware, inmates, by and large, are one of the most litigious groups of individuals that you will find. Inmates have sued the BOP and the Director for issues that range from loss of legal materials to being permitted to practice Satanism. Although many of these suits are frivolous, all suits filed by inmates must be properly addressed.

The BOP has a staff of attorneys to address inmate lawsuits, attorneys that are paid by tax dollars.

( When litigation occurs in a "contract" facility, it is unclear who will be responsible for responding to the suits and who will be liable for any judgement rendered against the "contract" facility? )

( If the BOP is still required to address lawsuits filed by inmates in "contract" facilities, where is the cost savings? )

The "contract" facility in Eloy, AZ was constructed using "private sector" funds. As we understand it, Concept, Inc. of Louisville, KY owns the Eloy facility "part and

parcel". This "ownership" is a significant motivating factor for Concept, Inc. to insure that their facility is not only properly run, but profitable.

Should Concept, Inc. violate their contract or in some other way "fail to perform", it is possible that Concept, Inc. could be left with an empty facility, devoid of any contract or profit.

However, the BOP proposes "turning over" facilities that have been constructed with tax dollars to a private contractor.

These "contractors" do not have any "true" investment in the facility, they simply "staff" and operate an existing or soon to be constructed institution.

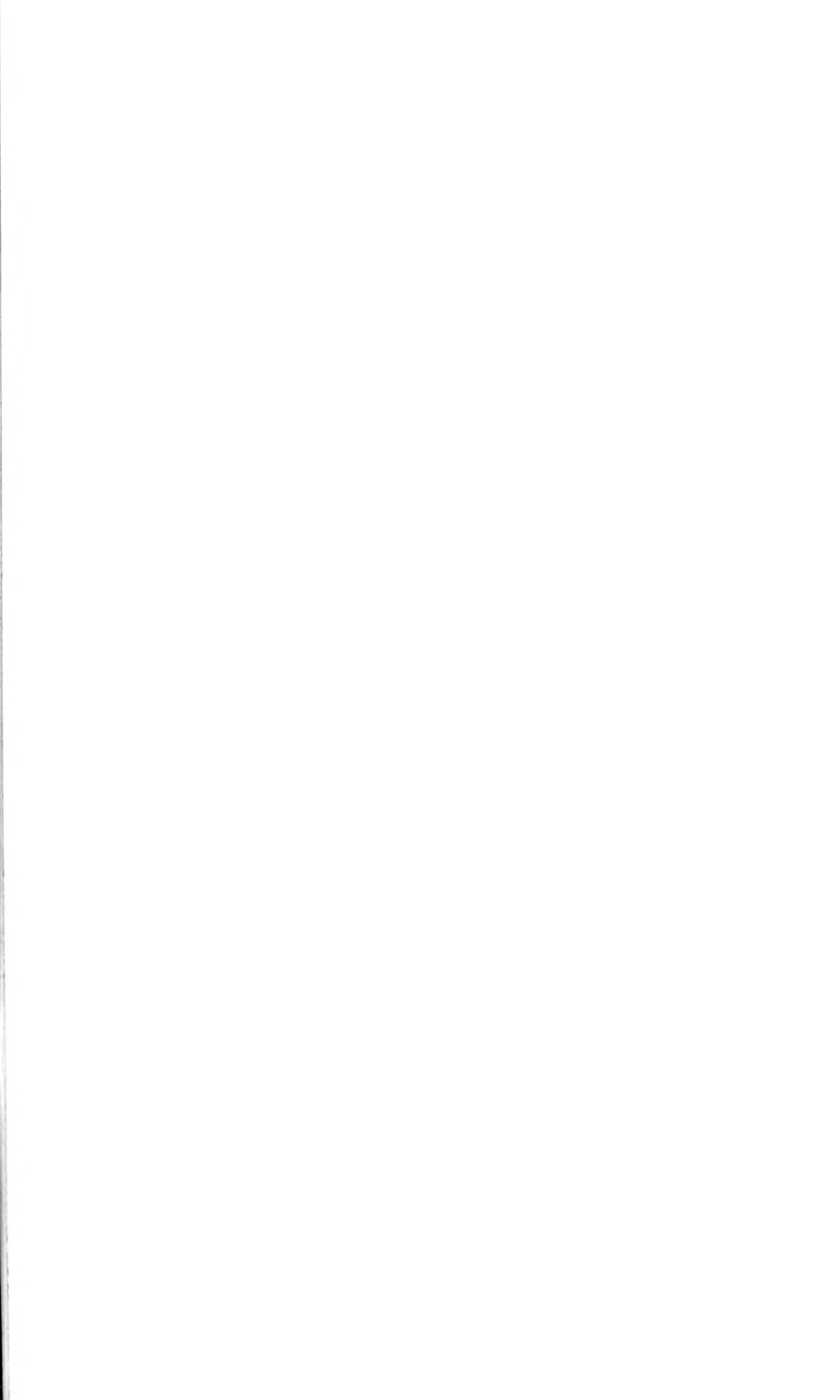
If one of these "contractors" has an unprofitable year, has too many serious incidents that decrease their "net" profits or encounters some other problem that affects their ability to earn a profit, then the "contractor" may opt to file bankruptcy or take some other legal action that divests them of any responsibility for the operation of their "contract" facility.

In closing, I respectfully request that consideration be given on the issues of increasing Federal Bureau of Prisons staffing and any decision on contracting out these new facilities be placed on hold. There needs to be an increase in staffing to compensate for the constant increase of inmates. The public and the Federal Bureau of Prisons employees deserve a full investigation into the motives, costs, and procedures involving the contracting out of these institutions. It does not make fiscal sense to "jump" into this program without proper studies and analysis. What we as a Union ask the committee is to investigate, study and analyze the data provided and make an informed decision on whether to go forward.

Mr. Chairman, I would like to thank you and members of the subcommittee for your time and I would be pleased to answer any questions you or your colleagues may have.



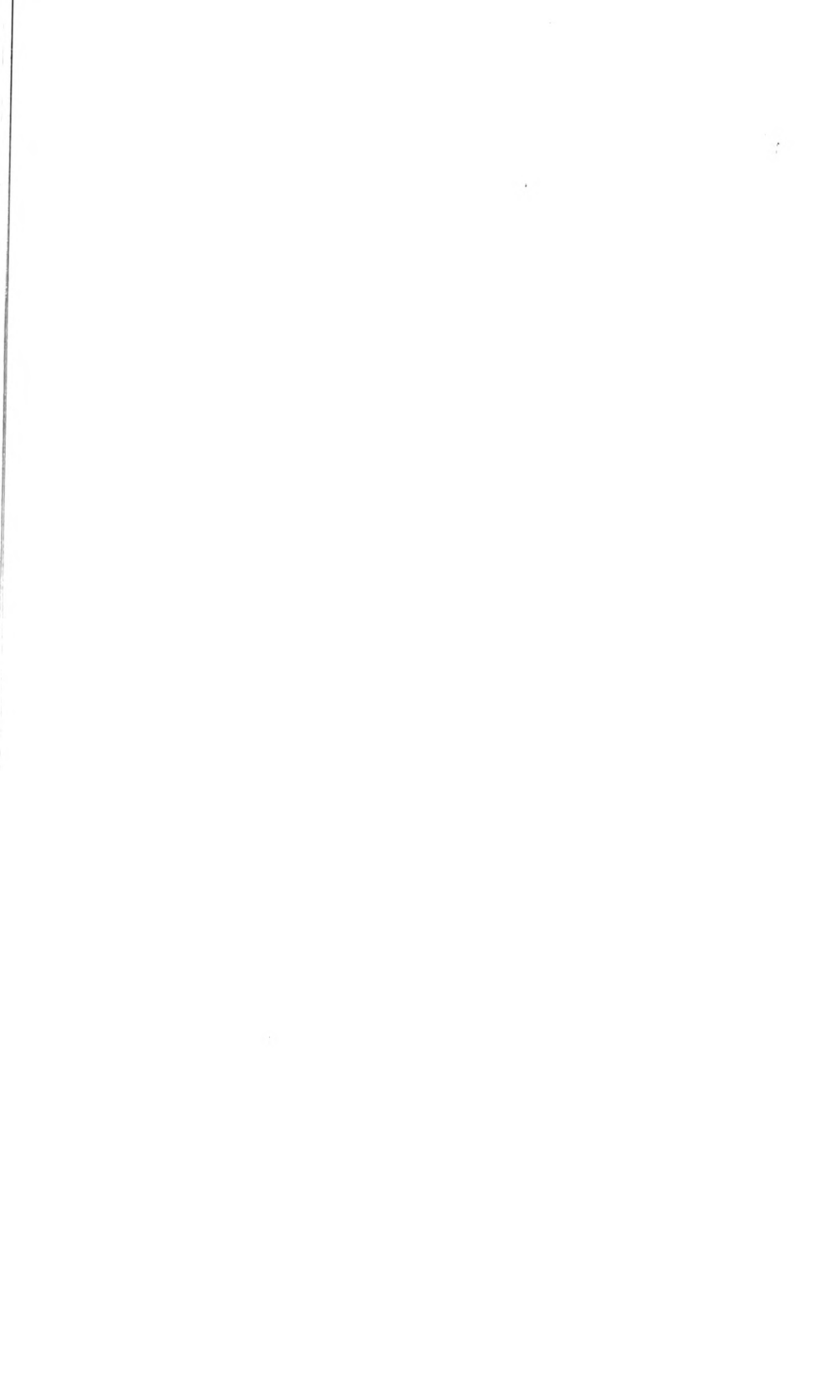




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